





Health Care Financing Administration

---

---

# **ADVISORY PANEL TO DEVELOP UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)**

---

---

**‘Report to Congress**

**December 1992**

---

# **REPORT TO CONGRESS**

## **Report of the Secretary's Advisory Panel on the Development of Uniform Needs Assessment Instrument(s)**

**U.S. Department of Health and Human Services  
Health Care Financing Administration**

**Order from Superintendent of Documents  
U.S. Government Printing Office  
Washington, D.C. 20402**

**Prepared for Printing  
December 1992**



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

JUN 30 1992

The Honorable Dan Quayle  
President of the Senate  
Washington, D.C. 20510

Dear Mr. President:.

I am respectfully submitting the report required by section 9305(h)(3) of the Omnibus Budget Reconciliation Act of 1986 (P.L. **99-509**), which directs the Secretary of the Department of Health and Human Services to submit to Congress a report on the development of a uniform needs assessment instrument. The law required this activity be undertaken in consultation with an advisory panel.

As directed by the enabling legislation, the uniform needs assessment instrument has been developed to assess an individual's needs for health-related or supportive care in terms of functional capacity, nursing and other care requirements and the availability of social and familial resources. It has been designed for potential use by health care professionals across the continuum of care, including hospitals, long term care facilities and home health agencies.

The enclosed report incorporates the recommendations of the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s). The report includes the needs assessment instrument and recommendations for its' use. It also presents an evaluation of the advantages and disadvantages of using the needs assessment instrument for determining whether payment should be made for post-hospital extended care services and/or home health services for Medicare beneficiaries.

The report contains an extensive discussion of discharge planning and relevant post-acute care issues. Initiatives being undertaken by the Department related to discharge planning, clinical assessment and mechanisms to evaluate the quality of transitional care are also discussed. A brief summary of the uniform needs assessment initiative, follow-up activities planned by the Department and related issues is enclosed.

Page 2 - The Honorable Dan Quayle

The report, however, raises concerns that Congress should carefully consider when reading the report. First, the report does not specify a screening methodology that would be required to determine who shall undergo a UNAI process. Implementation of the UNAI without a thorough and effective screening methodology risks excessive and unnecessary use and wasteful expenditures.

Second, the report does not demonstrate the need for even more discharge planning. The Medicare program already requires discharge planning activities for Medicare patients. In addition, seventy-three percent of hospitals report implementing new discharge procedures since 1983. The report suggests that a cost analysis of the UNAI be performed before implementation, as well as a comparison of the effectiveness of the UNAI as it relates to existing federal patient assessment instruments to eliminate overlap. The various assessment instruments should be coordinated to provide an effective data source for providers at each stage in the continuum of care.

At a time when the U.S. health care system is under increasing pressure to reduce administrative expenses, Congress should investigate unnecessary duplication of efforts that the UNAI may induce and require justification for additional **post-**acute care planning.

I am also sending a copy of this report to the Speaker of the House of Representatives.

Sincerely,

  
Louis W. Sullivan, M.D.

Enclosures



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

JUN 30 1992

The Honorable Thomas S. Foley  
Speaker of the House of Representatives  
Washington, D.C. 20515

Dear Mr. Speaker:

I am respectfully submitting the report required by section 9305(h)(3) of the Omnibus Budget Reconciliation Act of 1986 (**P.L. 99-509**), which directs the Secretary of the Department of Health and Human Services to submit to Congress a report on the development of a uniform needs assessment instrument. The law required this activity be undertaken in consultation with an advisory panel.

As directed by the enabling legislation, the uniform needs assessment instrument has been developed to assess an individual's needs for health-related or supportive care in terms of functional capacity, nursing and other care requirements and the **availability** of social and familial resources. It has been designed for potential use by health care professionals across the continuum of care, including hospitals, long term care facilities and home health agencies.

The enclosed report incorporates the recommendations of the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s). The report includes the needs assessment instrument and recommendations for its use. It also presents an evaluation of the advantages and disadvantages of using the needs assessment instrument for determining whether payment should be made for post-hospital extended care services and/or home health services for Medicare beneficiaries.

The report contains an extensive discussion of discharge planning and relevant post-acute care issues. Initiatives being undertaken by the Department related to discharge planning, clinical assessment and mechanisms to evaluate the quality of transitional care are also discussed. A brief summary of the uniform needs assessment initiative, follow-up activities planned by the Department and related issues is enclosed.

Page 2 - The Honorable Thomas S. Foley

The report, however, raises concerns that Congress should carefully consider when reading the report. First, the report does not specify a screening methodology that would be required to determine who shall undergo a UNAI process. Implementation of the UNAI without a thorough and effective screening methodology risks excessive and unnecessary use and wasteful expenditures.

Second, the report does not demonstrate the need for even more discharge planning. The Medicare program already requires discharge planning activities for Medicare patients. In addition, seventy-three percent of hospitals report implementing new discharge procedures since 1983. The report suggests that a cost analysis of the UNAI be performed before implementation, as well as a comparison of the effectiveness of the UNAI as it relates to existing federal patient assessment instruments to eliminate overlap. The various assessment instruments should be coordinated to provide an effective data source for providers at each stage in the continuum of care.

At a time when the U.S. health care system is under increasing pressure to reduce administrative expenses, Congress should investigate unnecessary duplication of efforts that the UNAI may induce and require justification for additional **post-**acute care planning.

I am also sending a copy of this report to the President of the Senate.

Sincerely,

  
Louis W. Sullivan, M.D.

Enclosures

---

# REPORT OF THE SECRETARY'S ADVISORY PANEL ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

## PREFACE

The United States health care delivery system is facing increasing pressures that challenge the ability of our health care institutions to provide care that meets our standards for quality and effectiveness. Continuing technological advances, powerful incentives to reduce costs, and an increased incidence of debilitating and chronic illnesses have resulted in more complex needs for continuing care, which has changed the post-acute care environment. The degree to which individuals receive necessary and appropriate care after discharge from a health care setting has been an issue of growing concern among consumers, providers and policy makers.

Health care consumers have expressed growing anxiety and alarm at the decreasing-length of the average hospital stay. This, in turn, has increased demands on the formal and, informal caregiver systems available to support individuals on their return to the community. Problems arise when necessary support is lacking.

Health care providers, faced with increasingly complex discharges, struggle to arrange necessary and appropriate posthospital services. Services may not be available or individuals may be denied access because of lack of funding. This situation has been complicated by the sometimes inconsistent and subjective interpretations regarding Medicare beneficiaries' eligibility for home health and extended care services that are made by fiscal intermediaries. Additionally, the reductions in availability and access to necessary

posthospital services that have resulted from cutbacks in human services and the expanding population of the uninsured and underinsured have further exacerbated the crisis of meeting the continuing health care needs of our society.

Responding to the changes in the health care environment and the concerns of both Medicare beneficiaries and providers, the 100th Congress believed that it was necessary to build safeguards into the system to ensure the quality of care provided to Medicare beneficiaries. A number of provisions related to health care quality were enacted as part of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86). The establishment of the Secretary's Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) was one of several provisions that addressed discharge planning and posthospital care services. The legislation required the Secretary of Health and Human Services to appoint a panel of experts representing health care consumers, hospitals, home health and extended care providers, and fiscal intermediaries to advise the Department on the development of a uniform needs assessment instrument.

The work of the Panel represents a significant accomplishment in collaboration and compromise. Despite the varied interests and perspectives represented on the Panel, its members were able to find common ground and focus on the shared interest of elevating the quality of the discharge planning process. It is to the credit of



---

Panel members that the group was able to subjugate the agendas of individuals to the broader goals of the uniform needs assessment initiative.

Significant contributions to the development of the uniform needs assessment instrument were made by every member of the Panel. Not only did each member bring to the process the unique expertise of his or her respective discipline, setting or constituency, but each supplied a vision and creativity, which collectively resulted in the breaking of new ground in the field of clinical assessment.

Much of the credit for the Panel's successful completion of its charge belongs to Sue Nonemaker, R.N., M.S., Project Officer for the Health Care Financing Administration's Health Standards and Quality Bureau (HSQB). Miss Nonemaker's depth of knowledge, analytical ability, organizational skills, attention to detail and perseverance were indispensable to the development of the needs assessment instrument and central to the production of this report. In addition, her resourcefulness, sense of humor and enthusiasm for this project made Sue a valued friend and partner during my role as Chairman.

We were fortunate to have a great deal of support and encouragement from HSQB management. I would particularly like to thank Thomas Morford, Director of HSQB, for his support over the extended two year life span of the Panel, as well as Wayne Smith, Ph.D., Director of the Office of Survey and Certification. We are appreciative of Dr. Smith's ongoing encour-

agement, advice and personal interest in clinical assessment issues, as well as his assistance in the preparation of this report.

I also want to thank the many individuals and numerous provider, professional discipline and beneficiary associations who participated in the process of developing the needs assessment instrument. We are grateful for their ongoing willingness to share their expertise and experience with the Panel and gratified by the degree of interest and support we received from the public. I would also like to recognize David Schulke, Chief Investigator for the Senate Special Committee on Aging, for his leadership in shaping the uniform needs assessment initiative and extend our appreciation for his continued interest in our efforts.

The Report of the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) includes both the Uniform Needs Assessment Instrument and recommendations regarding its use. This report also provides a description of the context and background of the uniform needs assessment initiative by reviewing its legislative and regulatory history, the evolution of discharge planning systems and relevant assessment technology. The later chapters of the report consider additional implications of the uniform needs assessment initiative related to determining eligibility for Medicare covered posthospital services, its use in quality assurance systems and legal considerations.

The Panel supports the implementation of a uniform system of needs assessment but ex-

---

pressed the need for a cautious approach to prevent a premature decision in that regard. The Panel strongly advised that a decision to mandate use of the instrument for the Medicare program be predicated on a thorough evaluation of the instrument's administrative feasibility and clinical effectiveness.

Secondly, the Panel expressed its concern that a more effective vehicle and process for evaluating post-discharge needs would be of value only if necessary institutional and community-based health and social services are available to meet identified needs. The trend of cutting funding for many vital community-based health and social services observed over recent years is antithetical to the goal of a uniform needs assessment process.

The Panel is hopeful that its proposed needs assessment instrument will both provide a uniform method of evaluating posthospital care needs that improves clinicians' abilities to care for individuals as well as establish the safeguard intended by Congress to ensure the quality of care provided to Medicare beneficiaries.

Jay Rudman  
Chairman, Advisory Panel on the  
Development of Uniform Needs  
Assessment Instrument(s)  
July, 1990



---

# REPORT OF THE SECRETARY'S ADVISORY PANEL ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

## EXECUTIVE SUMMARY

The uniform needs assessment initiative grew out of the concerns of legislators and regulators, health care providers and professional disciplines, and Medicare beneficiaries and other health care consumers regarding quality and access to necessary health care services. It was shaped by multifaceted changes in the health care delivery system and provider practice patterns, which evolved from a restructuring of reimbursement schemes, advances in technological capabilities, and epidemiological changes in patient case-mix and severity of illness.

During the past several years, much interest has centered on transitional care issues. Diverse regulatory and environmental factors have focused attention on the importance of clinical assessment processes to assure that an individual's needs for continuing care are appropriately and adequately evaluated and planned for prior to discharge from each care setting.

The needs assessment is a primary component of discharge planning, the process of assessing needs and making arrangements to meet an individual's needs for continuing care as he or she moves through the health care system. Discharge planning has traditionally been viewed as a responsibility of hospitals, with discharge planning systems and procedures generally more sophisticated and formalized in hospitals than in other types of care settings. However, the expansion of technological capabilities and increased utilization of post-acute care services has

required that providers of post-hospital services become more broadly involved in assessing continuing care needs and planning for discharge from non-acute care settings.

Despite consensus on the increased importance of systematic assessment and planning for continuity of care, there exists much variation in needs assessment practices and the knowledge and expertise of discharge planning professionals. A Congressional investigation found evidence of poor quality discharge planning services, with the welfare of individuals threatened by inappropriate or incomplete discharge planning. Investigators also found tremendous diversity in the processes by which needs for continuing care were assessed.

The need to assure the quality and appropriateness of care provided across various settings as well as access to necessary post-hospital services provided the impetus behind the Congressional charge to develop a uniform needs assessment instrument. Support for uniformity in the needs assessment process was established during the 1985-86 Senate Special Committee on Aging's Quality of Care Hearings, from which emanated a recommendation to identify a core of critical information for the needs assessment. This was intended as a means to assure that necessary information was considered in discharge planning as well as to promote coordination of care across different settings and by various providers.

---

In the Omnibus Budget Reconciliation Act of 1986, the Secretary of Health and Human Services was charged with the development of a uniform needs assessment instrument. This activity was to be undertaken in consultation with an advisory panel of experts in the delivery of post-hospital services including representatives of hospitals, physicians, skilled nursing facilities, home health agencies, fiscal intermediaries and Medicare beneficiaries.

The uniform needs assessment instrument (UNAI) developed by the Secretary's Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) is a four page form. The needs assessment process is structured to collect critical information according to the following domains: Sociodemographics, Health Status, Functional Status, Environmental Factors in Post-Discharge Care, Nursing and Other Care Requirements, Family and Community Support, Patient/Family Goals and Preferences, and Options for Continuing Care.

The Panel's deliberations to develop the UNAI were shaped by one primary goal. This goal was to achieve a critical balance between quality of care and operational concerns: to develop an instrument that would improve post-hospital care by providing a thorough and valid evaluation of continuing care needs and also be capable of use across diverse care settings, thereby providing uniformity in the assessment of post-hospital needs.

The Panel felt strongly that the needs assessment process requires the active participation of

the patient and family. To assure an appropriate level of participation in this process, the Panel recommended a separate form be attached to the UNAI for the patient's/patient representative's signature, as a means of attesting to the patient's participation in the process.

The -Panel was also charged with making recommendations regarding the appropriate use of the needs assessment instrument. It ratified several recommendations regarding the use of the UNAI and the potential establishment of a uniform system of needs assessment. These recommendations focused on the purpose of the instrument, necessary qualifications of the assessor, training necessary to promote uniform use of the instrument, the process for performing the assessment, timing of the assessment, resources necessary to administer the instrument, population to which the instrument should be administered, use of the instrument in non-acute care settings, coordination of data elements, mechanisms to assure accountability for the performance and reliability of the assessment, and future testing and evaluation of the instrument.

The Panel viewed the primary purpose of the needs assessment instrument as determining an individual's needs for continuing care. The UNAI was not developed to replace a comprehensive geriatric or functional assessment, to serve as a care plan or to be the primary means by which decisions regarding eligibility for Medicare covered services are made.

The UNAI was developed for use by qualified and trained personnel without restriction to

---

a professional group or discipline. Such personnel would be supervised by a registered nurse, social worker or other qualified personnel. Individuals performing the needs assessment would undergo training in its use, with a uniform system of training developed to promote consistent application of the instrument. The process by which the instrument would be completed is flexible, with each health care setting responsible for designating those individuals responsible for coordinating input and completing the assessment.

In defining the population for which the instrument should be used, the Panel felt it should be administered to those individuals that require a more extensive discharge planning evaluation, as identified by uniform high risk screening criteria applied to all Medicare patients. This framework is consistent with that of the proposed Medicare Discharge Planning-Condition of Participation for hospitals, in which administration of the UNAI would be one means of performing the in-depth evaluation of continuing care needs that is required prior to the development of a discharge plan.

As specified in the enabling legislation, the UNAI was developed for use not only in hospitals but in multiple care settings to identify needs for continuing care. The instrument could be administered periodically to assure that needs were accurately identified as well as to evaluate continuing care needs when discharge from a setting is contemplated. Needs assessment data could be transferred to the next provider to promote continuity of care and contribute to the initial data

base used to plan care by the receiving provider.

The Panel believed that efforts should be made to minimize duplicative requirements for documentation of patient-centered information. Recognizing that this may not be possible when the purpose of assessments differs, the Panel maintained that the UNAI should be studied in relation to other existing Federal assessment requirements, with efforts directed towards consolidation and standardization of data elements.

The Panel was required to evaluate the advantages and disadvantages of using the uniform needs assessment instrument as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to Medicare beneficiaries. The Panel concluded that the UNAI should not be the primary source of information for eligibility determinations. However, it was also felt that the UNAI could supplement the current eligibility determination process by providing fiscal intermediaries with a more complete picture of a beneficiary's continuing care needs. In addition, the Panel offered recommendations for further study in the development of functionally and socially based models to determine eligibility for long-term care programs and discussed the UNAI's potential role in the Department's effectiveness initiative.

The Panel felt that a uniform system of needs assessment would have many secondary uses such as quality assurance and compilation of a data base for research and policy formulation. Potential uses in Federal quality assurance ef-

---

forts include survey and certification and the Peer Review Organization (PRO) programs. The UNAI could provide an effective tool for surveyors to monitor discharge planning requirements. The UNAI could also serve as a primary source of data and an objective means for PRO staff members to evaluate the quality of the needs assessment and discharge planning processes for which hospitals, home health agencies and long term care facilities are responsible. By including outcome-oriented, functionally based measures of an individual's status, the Panel also suggested that the UNAI could be used in quality assurance studies of post-acute care to evaluate the quality of transitional care. It could also be used in longitudinal studies of the composite effectiveness of care provided across various care settings or by numerous providers.

The Panel was concerned that implementation of a uniform system of needs assessment might have an impact on the liability of providers. Reviews of relevant literature and expert legal testimony provided to the Panel suggested that the legal responsibility of providers to assess an individual's continuing care needs exists regardless of the presence or absence of a uniform needs assessment instrument. It was further postulated that documentation of post-hospital care needs as identified by the UNAI would not increase the assessor's or institution's obligation to assure the availability of resources to meet all identified needs.

The Panel made several recommendations for further study, calling for the UNAI to be field

tested in a representative sample of hospitals, home care agencies and long term care facilities to establish the reliability, validity and administrative feasibility of the instrument. In the event that use of the UNAI is mandated, the Panel strongly recommended that careful consideration should be given to issues such as the resources necessary to implement such a system, the need for flexibility to accommodate variations in care settings and delivery systems and the duplicative requirements that currently exist for reporting of patient information, prior to implementation of a uniform system. Should the instrument be mandated, a long term evaluation should be conducted, in part to address the impact of the assessment process on the problem of patients being discharged without their needs for continuing care being met.

There are numerous advantages associated with implementation of a uniform system of needs assessment. Requiring use of the UNAI would assure that the continuing care needs of Medicare beneficiaries are appropriately evaluated prior to discharge. The structure of the UNAI would also enhance a beneficiary's opportunities to have input into the discharge planning process. Uniform use of the UNAI would provide a comprehensive structure for completion of the needs assessment portion of a provider's discharge planning responsibilities. It would also enhance continuity of care and communication of beneficiaries' needs across care settings, by drawing upon a common methodology and language to evaluate extended care needs.

---

The Panel supported the implementation of a uniform system of needs assessment but expressed the need for a cautious approach to prevent a premature decision in that regard. The Panel strongly advised that a decision to mandate use of the instrument for the Medicare program be predicated on a thorough evaluation of the instrument's administrative feasibility and clinical effectiveness.





ADDRESSOGRAPH:

**ASSESSMENT OF NEEDS FOR  
CONTINUING CARE**

**I. SOCIODEMOGRAPHICS**

Attach Admission Face Sheet. List the following information if not otherwise available.

A. Name (Last, First, Middle Initial):		B. Address:		C. Phone No.
D. Birthdate:	E. Sex <input type="checkbox"/> M <input type="checkbox"/> F	F. Marital Status: <input type="checkbox"/> Married <input checked="" type="checkbox"/> <b>Separated</b> <input type="checkbox"/> Single <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown	G. Religious Preference: <input type="checkbox"/> Catholic <input type="checkbox"/> Jewish <input type="checkbox"/> Protestant <input type="checkbox"/> Other <input type="checkbox"/> Unknown	H. Date of Admission:
I. Race <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input checked="" type="checkbox"/> <b>Hispanic</b> <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		J. Education: (Highest Level Attained)	K. Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Unknown	
L. Health Care Coverage: Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Private Inurer (Specify _____) <input type="checkbox"/> Veteran with service connected disability		M. Does the Patient Speak English? If no, primary language: _____		

**II. HEALTH STATUS**

A. Reason for Admission:	B. <b>Diagnosis(es)</b> (Principal and Secondary):	C. Surgical Procedure(s)
--------------------------	--	--------------------------

D. Current or Recent Health Problems/Risk Factors that May Affect Post-Discharge Care Needs

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Head Injury	<input type="checkbox"/> c I Arthritis	<input type="checkbox"/> Falls/Unsteadiness
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> <b>Alzheimers/Other</b> Dementias	<input type="checkbox"/> Contractures	<input type="checkbox"/> Impaired Vision
<input type="checkbox"/> Renal Disease	<input type="checkbox"/> <b>Parkinsons/Other</b>	<input type="checkbox"/> Amputations	<input type="checkbox"/> Impaired Hearing
<input type="checkbox"/> Diabetes	Neurodegenerative Disease	<input type="checkbox"/> Pressure Ulcer	<input type="checkbox"/> Substance Misuse: _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> <b>Psychiatric</b> Disorder	<input type="checkbox"/> c I Obesity	<input type="checkbox"/> Non-Adherence with Therapeutic Regimen
<input type="checkbox"/> CVA	<input type="checkbox"/> c I Chronic Pain	<input type="checkbox"/> c I Food/Fluid Intake Problem	<input type="checkbox"/> Other: _____

E. Level of Consciousness: ☐ **Alert (awake, responsive)** ☐ Semi-conscious (lethargic, drowsy, obtunded or stuporous) ☐ Comatose (unresponsive)

F. Check Those Cognitive/Behavioral Factors that May Affect Post-Discharge Care Needs:

<input type="checkbox"/> Impaired Orientation (unaware of person, place or time)	<input type="checkbox"/> Delusions <b>and/or</b> Hallucinations (perceives what does not exist; thoughts of persecution, paranoia or grandiosity)
<input type="checkbox"/> Impaired Memory (forgetful to the point of being dysfunctional)	<input type="checkbox"/> Wandering (does not understand territorial constraints, leading to unsafe situations)
<input type="checkbox"/> Impaired Comprehension (difficulty in understanding spoken or written directions)	<input type="checkbox"/> Agitation (anxiety; restlessness)
<input type="checkbox"/> Impaired Expression ( <b>difficulty</b> in communicating needs verbally or in <b>writing</b> )	<input type="checkbox"/> Physically Assaultive (strikes self or other, causing dangerous condition)
<input type="checkbox"/> Impaired Judgment (unsafe self-direction: inconsistency in care decisions)	<input type="checkbox"/> Suicidal (HX attempts; verbalizes <b>thoughts/plan</b> )
<input type="checkbox"/> Depression (appears sad, helpless, hopeless; has difficulty with concentration, sleep <b>and/or</b> appetite)	<input type="checkbox"/> Unusual Behavior (inappropriate <b>verbalization</b> ; <b>reclusiveness</b> ; hoarding)
	<input type="checkbox"/> Other: _____

G. Additional Information Regarding Patient's Condition that Affects Post-Discharge Care Needs:

### III. FUNCTIONAL STATUS

See manual for complete definitions and instructions. Rate observed or reported performance only. Rating assumes patient is able to function safely.

#### A. Rate Level of Independence for the Following:

(Minimal assistance defined as including the **need** for supervision, verbal cueing or minimal physical assistance. **Moderate** assistance implies **the need** for physical assistance.)

Activities of Daily Living	Independent	Minimal Assistance	Moderate Assistance	Dependent	Assistive Device(s) Needed to Perform Activity
Eating (ad of bringing <b>food</b> to mouth, chewing and swallowing)					
Bathing (bathing body, excluding back and shampooing hair)					
Dressing (setting out clothing and dressing entire body, including necessary <b>prosthesis/orthosis</b> )					
Toilet Use (use of toilet, urinal, bedpan; <b>includes</b> cleansing <b>self</b> after elimination and adjusting <b>clothing</b> )					
Bowel Management (intentional control of bowel movements; includes use of agents necessary for bowel control)					
Bladder Management (intentional control of urinary bladder; includes use of agents necessary for bladder control)					
Transfer (transferring to and from bed, chair or wheelchair; includes coming to a standing position)					
Locomotion (includes walking, once in a standing position; using a wheelchair indoors)					

#### B. Additional Assistive Devices Currently In Use:

- ☐ Glasses  
☐ Dentures  
☐ Heating Aid  
☐ Other \_\_\_\_\_ (Specify)

#### C. Instrumental Activities of Daily Living (complete only if considering return to a community residence):

	Independent	Needs Assistance	Unknown
Meal Preparation (includes cooking food and setting up meat)			
Medication Administration			
Telephone Use			
Housekeeping			
Shopping			
Handling Finances			
Transportation Use			

Check most frequent mode of locomotion at **discharge**: ☐ Walking ☐ Wheelchair

#### D. Communication

Comprehension (Ability to understand auditory or visual **communication**)

- ☐ Able to understand directions  
☐ Can follow directions with minimal prompting, repetition  
☐ Has **difficulty** following directions, needs constant prompting  
☐ Unable to **follow** simple directions

Expression (Ability to communicate basic daily needs)

- ☐ Expresses needs clearly  
☐ Expresses needs **slowly** or requires minimal prompting  
☐ Expresses needs with **difficulty**, requiring much prompting  
☐ Unable to express needs

Usual Mode(s) of Communication

- ☐ Speech  
☐ Writing  
☐ Gestures/Sounds  
☐ Sign Language  
☐ Communication Device

#### E. List Restrictions that Would Affect Ability to Perform Above Functions:

### IV. ENVIRONMENTAL FACTORS IN POST-DISCHARGE CARE

#### A. Usual Living Arrangements:

- ☐ House/Apartment ☐ Alone  
☐ Rented Room ☐ With Spouse  
☐ Board and Care/Personal Care Facility/Retirement Home, ☐ With Others (Specify) \_\_\_\_\_  
☐ Nursing Facility  
☐ Other \_\_\_\_\_

Are noninstitutional living arrangements available? ☐ Yes ☐ No

#### B. Environmental Barriers

	Yes	No	Comments:
Are there barriers to building entry/exit?			
Are there internal barriers? (stairs, narrow doorway)			
Is toilet/tub/shower accessible?			
Is the patient able to access emergency assistance?			
Other Barriers (Specify):			

## V. NURSING AND OTHER CARE REQUIREMENTS

Check Anticipated Needs for Continuing Care:

### A. Therapeutic Needs:

1. Skin: ☐ Pressure Ulcer Care: Stage \_\_\_\_\_ Site ☐ Drainage/Culture Care: \_\_\_\_\_

☐ Wound Care: \_\_\_\_\_ Stage \_\_\_\_\_ Site ☐ Drainage/Culture Care: \_\_\_\_\_

2. Nutrition: ☐ Therapeutic Diet (Specify) \_\_\_\_\_

☐ Enteral Feeding: ☐ Nasogastric ☐ Gastrostomy Frequency: \_\_\_\_\_

☐ Parenteral Feeding: Frequency: \_\_\_\_\_

3. Hydration: ☐ Encourage fluids ☐ Restrict Fluids

c I Intravenous Hydration Route: ☐ Peripheral CI Central

Frequency: \_\_\_\_\_

4. Respiratory: ☐ Oxygen: ☐ Continuous ☐ Intermittent Frequency: \_\_\_\_\_

Delivery Method and Liter Fbw: \_\_\_\_\_

☐ Tracheostomy: ☐ Temporary ☐ Permanent Frequency of Care: \_\_\_\_\_

☐ Suctioning: Frequency: \_\_\_\_\_

☐ Ventilator: ☐ Temporary ☐ Permanent

5. Elimination: c I Urinary Catheter: ☐ Indwelling ☐ Intermittent

Size: \_\_\_\_\_ Insertion Date: \_\_\_\_\_ Irrigation and Frequency of Care: \_\_\_\_\_

☐ Ostomy: **Type** and Frequency of Care: \_\_\_\_\_

☐ Dialysis: ☐ Hemo CI Peritoneal ☐ CAPD Treatment Frequency: \_\_\_\_\_

### 6. Administration/Management of Medications:

☐ Oral

☐ Subcutaneous/Intramuscular: Frequency \_\_\_\_\_

☐ Intravenous: ☐ Antibiotics ☐ Chemotherapy ☐ Blood Products

Frequency: \_\_\_\_\_

☐ Implanted Pump: Frequency: \_\_\_\_\_

☐ Other: \_\_\_\_\_

7. c I Skilled Nursing Observation: \_\_\_\_\_

6. ☐ Supervision/Evaluation: \_\_\_\_\_

9. ☐ Other Care Needs: \_\_\_\_\_

### B. Patient/Family Educational Needs:

☐ Self-Care Activities

☐ Self-Management of Illness

☐ Diet Instruction

c I Medication Administration

☐ Ostomy Care

☐ Wound Care/Dressing Change

☐ Tracheostomy Care/Suctioning

☐ Other \_\_\_\_\_

## VI. FAMILY AND COMMUNITY SUPPORT

### A. Source(s) of Support:

Primary Support	Relationship	Type of Support (physical, psycho- logical, social and/or economic)	Availability	Limitations or Constraints
Name: _____				
Address: _____				
Phone: _____				
Other Caregiver: _____				
<input type="checkbox"/> No Known Support				

### B. Community Services Utilized Prior to Admission:

Home Health Services \_\_\_\_\_  
Homemaker **Services** \_\_\_\_\_  
**Equipment/Supplies** \_\_\_\_\_  
Meals to Homebound \_\_\_\_\_  
Transportation \_\_\_\_\_  
Adult Day Care \_\_\_\_\_  
Mental Health Services \_\_\_\_\_  
Hospice \_\_\_\_\_  
Respite \_\_\_\_\_  
Case Management \_\_\_\_\_  
Other \_\_\_\_\_

### C. Additional Assistance Needed (For Home Care):

D. Physician Responsible for Follow-up Care (Name/Phone No.): \_\_\_\_\_

E. ~~Other~~ Individual Responsible for Coordinating Care (Name/Phone No.): \_\_\_\_\_

# VII. PATIENT/FAMILY GOALS AND PREFERENCES

A. Patient's Goals and Preferences for Continuing Care:

C. Religious or Ethnic Practices that May Affect **Needs** or Preferences for Continuing Care:

B. Family/Caregiver's Preferences for Continuing Care:

D. **Decision-Making** Support:

	Already Has	Desires/Requires
Durable Power of Attorney for Health Care <b>Decision-Making</b>		
Living Will .....		
Guardian/Conservator .....		

E. Surrogate Decision-Maker (Name/Phone No.):

# VIII. OPTIONS FOR CONTINUING CARE

A. Therapy/Service **Needs**:

<input type="checkbox"/> Nursing	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Social Work
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Other _____

B. Durable Medical **Equipment/Supply** Needs:

<input type="checkbox"/> Bed	<input type="checkbox"/> Siderails	<input type="checkbox"/> Trapeze	<input type="checkbox"/> Commode
<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Oxygen	
<input type="checkbox"/> Other:	_____		
<input type="checkbox"/> Disable Supplies:	_____		

C. The Following Options are Consistent with the Patient's Needs:

<input type="checkbox"/> Home (no additional services necessary)	<input type="checkbox"/> Other community services (Specify Type ) _____
<input type="checkbox"/> Relative's home	<input type="checkbox"/> Rehabilitation facility
<input type="checkbox"/> Home with home care services	<input type="checkbox"/> Board and care/personal care facility/retirement home
(Specify Type _____)	<input type="checkbox"/> Nursing Facility
<input type="checkbox"/> Outpatient (Specify Type ) _____	<input type="checkbox"/> Hospice
<input type="checkbox"/> Adult day care	

D. Needs/Options Have Been Discussed with: ☐ patient ☐ family/representative ☐ not discussed

Remarks:

Discharge Planner/Coordinator's Signature:

Date:

---

REPORT OF THE SECRETARY'S ADVISORY PANEL ON THE  
DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

TABLE OF CONTENTS

<b>Chapter 1:</b>	<b>Introduction .....</b>	<b>1</b>
<b>Chapter 2:</b>	<b>Background and Concerns Leading to the Uniform Needs Assessment Initiative.....</b>	<b>3</b>
	A. Needs Assessment as a Component of the Discharge Planning Process .....	3
	B. Roles and Responsibilities of Professionals Involved in Assessing Needs and Planning for Discharge .....	7
	C. Impact of the Regulatory System on the Evolution of Discharge Planning .....	10
	D. Variations in Discharge Planning Practices .....	15
	E. Environmental Factors .....	20
	F. Congressional Concerns Regarding the Adequacy of Discharge Planning for the Post-hospital Needs of Patients .....	24
	G. Issue to Address: Lack of Standardization in the Needs Assessment Process .....	28
<b>Chapter 3:</b>	<b>Issues in Clinical Assessment for Post-hospital Care Decision-making .....</b>	<b>35</b>
	A. Consensus Building on Assessment Methodology .....	35
	B. Overview of Assessment Domains .....	37
	C. Multidimensional Assessment Instruments .....	49
	D. Issues in Instrument Design and Evaluation .....	52
	E. Health Care Financing Administration Initiatives in the Development of Standardized Assessment Methodologies .....	53

<b>Chapter 4:</b>	<b>The Uniform Needs Assessment Instrument (UNAI): Content Issues . . . . .</b>	<b>65</b>
	A. Process Used by the Panel to Develop the Instrument . . . . .	65
	B. Scope of the Needs Assessment . . . . .	71
	C. Sources of Information and Interdisciplinary Contribution to the Needs Assessment . . . . .	.76
	D. Issues in Content.. . . .	.78
<b>Chapter 5:</b>	<b>Recommendations Regarding the Use of the Uniform Needs Assessment Instrument . . . . .</b>	<b>91</b>
	A. Purpose of the Instrument . . . . .	.91
	B. Qualifications Needed by the Assessor . . . . .	93
	C. Training and Uniform Use of the Instrument . . . . .	.95
	D. Process for Performing the Assessment . . . . .	.98
	E. Timing of the Assessment . . . . .	.99
	F. Resources Necessary to Administer the Instrument . . . . .	100
	G. Population to which the Instrument Should Be Administered . . . . .	101
	H. Use of the Instrument in Non-Acute Care Settings . . . . .	102
	I. Coordinating Data Elements . . . . .	105
	J. Mechanisms to Ensure Accountability for Performance and Reliability of the Assessment . . . . .	.106
	K. Testing and Evaluation . . . . .	107
<b>Chapter 6:</b>	<b>Additional Considerations . . . . .</b>	<b>111</b>
	A. Liability Concerns Associated with the UNAI. . . . .	111
	B. Use of the UNAI for Quality Assurance.. . . .	.118
	Survey and Certification . . . . .	118
	Peer Review Organization (PRO) Review . . . . .	122
	Other Quality Assurance Studies of Post-Acute Care . . . . .	125
	C. Using the UNAI to Compile a National Data Base for Research and Policy Decisions . . . . .	125

---

---

<b>Chapter 7:</b>	<b>Evaluation of the Advantages and Disadvantages of Using the Needs Assessment Instrument for Eligibility Determinations .....</b>	<b>* ..... 133</b>
A.	Overview of <b>Administration</b> of Medicare Benefits .....	133
B.	Evolution of Benefits Provided Under the Medicare Program .....	134
C.	Information Required to Determine Eligibility for Post-hospital Services Under the Medicare Program .....	135
D .	Use of the UNAI for Eligibility Determination .....	138
E.	Potential Contributions of the Instrument to the Process of Eligibility Determination .....	143
F.	Other Potential Uses Related to Eligibility Determination.. ..	145
G.	Use of Needs Assessment Methodologies in Public Policy .....	148
H.	Development of a Uniform Needs Assessment Instrument for Eligibility Determination .....	153
I.	Recommendations for Further Study .....	155
 <b>Chapter 8:</b>	 <b>Summary and Recommendations for Further Study .....</b>	 <b>159</b>
A.	Advantages Associated with Uniform Use of the UNAI .....	159
	Advantages for Providers .....	160
	Advantages for Beneficiaries .....	161
	Additional Advantages .....	162
B.	Recommendations for Further Study .....	162
	Field Testing .....	163
	Development of a Uniform System of Assessor Training .....	163
	Coordination with Other Federal Initiatives .....	164
	Development of a Uniform Screening Process .....	164
	Use of the UNAI for Eligibility Determinations .....	165
C.	Conclusions .....	166



---

## Appendices

Appendix A:	Enabling Legislation .....	173
	Advisory Panel Charter .....	174
Appendix B:	Advisory Panel Roster .....	179
	Biographical Sketches of Advisory Panel Members .....	180
Appendix C:	Overview and Executive Summaries of Advisory Panel Meetings .....	187
	• June 1-2, 1988 .....	193
	. August 3-4, 1988 .....	195
	• September 26-27, 1988 .....	197
	• December 7-8, 1988 .....	200
	• February 22-23, 1989 .....	202
	. July 24-25, 1989 .....	205
Appendix D:	Summary of HCFA-Solicited Comments on Initial Draft of the Uniform Needs Assessment Instrument .....	211

---

## CHAPTER 1: INTRODUCTION

Section 9305(h) of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86) mandated the development of a uniform needs assessment instrument (UNAI) by the Secretary of Health and Human Services.

The enabling legislation directed that a needs assessment instrument be developed according to the following parameters:

- o it should be capable of evaluating a patient's requirements for post-hospital extended care services, home health services and long-term care services of a health-related or supportive nature;
- o it should be capable of being used by discharge planners, hospitals, nursing facilities, other health care providers and fiscal intermediaries; and
- o it should include measures of:
  - functional capacity;
  - the nursing and other care requirements necessary to meet healthcare needs and to assist with functional incapacities, and
  - the social and familial resources available to the individual to meet requirements for care.

Use of the term "uniform" in the enabling legislation suggests the potential to use the needs assessment instrument in the assessment of patients' needs for a variety of post-hospital services. The enabling legislation authorized the Secretary to use his discretion in considering whether to develop more than one instrument for

use in different situations.

OBRA '86 required that the instrument be developed in consultation with an advisory panel. The constituency of the panel was specified to include experts in the delivery of post-hospital extended care services, home health services and other long-term care services, as well as representatives of hospitals, physicians, skilled nursing facilities, home health agencies, other long-term care providers, fiscal intermediaries and Medicare beneficiaries.

The Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) was chartered in May 1987, and 18 members were appointed by Secretary Bowen in March 1988. The Panel roster and a biographical sketch of Panel members is included in Appendix B of this report.

The Panel's charter directed the Panel to report to the Secretary of Health and Human Services and the Administrator of the Health Care Financing Administration (HCFA) on the instrument(s) developed. Additionally, the charter included a charge for the Panel to make recommendations on the appropriate use of the instrument(s), including an evaluation of the advantages and disadvantages of using the instrument(s) as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to Medicare beneficiaries. The Panel was charged with developing an instrument(s) that was sensitive to the needs of individual patients and yet able to be applied across institutions and health care settings. The enabling

---

legislation and Panel's charter are found in Appendix A.

The Panel conducted its deliberations during a thirteen month period. Six meetings were held from June 1988, to July 1989. Executive summaries of the Panel's meetings are found in Appendix C. Meetings were open to the public, with opportunities for public comment. In addition, the Panel undertook a period of informal review and comment on its preliminary recommendations by experts in the health care delivery field. Feedback from the field was used to formulate the Panel's final recommendations to the Secretary.

Staff support for the Panel's proceedings and the preparation of this report was provided by HCFA's Health Standards and Quality Bureau.

This final report of the Advisory Panel provides an overview of the issues that shaped the uniform needs assessment initiative as well as background information on discharge planning and continuing care assessment. The report then summarizes the Panel's deliberations on the content of the UNAI, and presents the instrument itself and recommendations for its use. The remainder of the report, focuses on additional considerations associated with the uniform needs assessment initiative, reflecting on liability implications for providers as well as the potential use of the UNAI for quality assurance activities, the generation of a clinically-oriented data base and the use of the instrument for determining a patient's eligibility for Medicare covered services. The report concludes by offering direc-

tions for future study that would be necessary to implement a uniform system of needs assessment.

It is difficult to determine which measures of a patient's needs for care and the availability of a support system are the critical indicators to identify options for continuing care in a reliable manner. However, the real challenge to the Panel was to design an instrument that had both clinical validity and sufficient flexibility that it could be considered as a means of assessing care needs from a national regulatory perspective.

The remainder of the Panel's report is presented in seven chapters:

- o Chapter 2: Background and Concerns Leading to the Uniform Needs Assessment Initiative
- o Chapter 3: Issues in Clinical Assessment for Post-hospital Care Decision-making
- o Chapter 4: The Uniform Needs Assessment Instrument: Content Issues
- o Chapter 5: Recommendations Regarding the Use of the Uniform Needs Assessment Instrument
- o Chapter 6: Additional Considerations
- o Chapter 7: Evaluation of the Advantages and Disadvantages of Using the Needs Assessment Instrument for Eligibility Determinations
- o Chapter 8: Summary and Recommendations for Further Study

---

## CHAPTER 2: BACKGROUND AND CONCERNS LEADING TO THE UNIFORM NEEDS ASSESSMENT INITIATIVE

A number of factors converged to create the legislative environment that called for the development of a uniform needs assessment instrument. The decade of the eighties saw profound transformations in the health care delivery system. It is difficult to attribute causality, but changes in health care reimbursement schemes, coupled with changes in facility case-mix, patient severity, provider practice patterns and advances in technological capabilities, provided the fuel for Congressional concerns regarding quality and access to necessary post-hospital services for Medicare beneficiaries.

Provider, professional/clinical and beneficiary communities played a large role in molding these issues. Clinicians and administrators voiced the concerns of providers, who felt increased pressures to perform discharge planning for patients with complex needs, constrained by often limited resources. The comments of beneficiaries and their families reflected their frustration and/or fear when confronted with shortened hospital stays and discharge to the community with continuing care needs that previously may have been resolved during the course of hospitalization. In some cases, post-hospital needs were not appropriately evaluated; in other cases, an inappropriate discharge plan resulted in unmet needs for continuing care.

While the reality of limited resources had forced a restructuring of the Medicare reimbursement system and different utilization of service patterns, a Congressional investigation

found the system lacked many of the safeguards necessary to ensure that beneficiaries' needs for post-hospital care were consistently evaluated and met. Of note was the lack of a standardized assessment instrument and process by which to evaluate a patient's needs for continuing care. Congress responded by enacting Section 9305 of the Omnibus Budget Reconciliation Act of 1986 (OBRA '86), which required the development of a uniform needs assessment instrument by the Secretary of Health and Human Services, in consultation with an advisory panel (Section 9305(h)).

This chapter will examine the factors that shaped the uniform needs assessment initiative. It will also provide an overview of clinical practice and operational system issues related to needs assessment and the larger discharge planning process in order to examine the context in which a uniform system of needs assessment could be introduced.

### **A. NEEDS ASSESSMENT AS A COMPONENT OF THE DISCHARGE PLANNING PROCESS**

The assessment of needs for continuing care is but one aspect of the discharge planning process. It is sometimes difficult to distinguish between the needs assessment itself and the broader activity of discharge planning; while generally not appropriate, the terms are sometimes used interchangeably.

---

Much of this chapter focuses on the broader concepts of discharge planning and other continuity of care issues to portray the context in which the needs assessment usually occurs. To delineate the relationship of the needs assessment to discharge planning, the discharge planning process is conceptualized as including the following components:

- o screening;
- o needs assessment;
- o decision-making:
  - identification of patient preferences;
  - evaluation of available resources;
  - identification of options;
  - development of discharge plan;
- o implementation:
  - education for self-care;
  - generation of referrals; and
- o evaluation and follow-up of plan (Nonemaker, unpublished paper).

The uniform needs assessment initiative encompasses the components of screening and needs assessment. As envisioned by the Panel, the needs assessment instrument would be administered to patients at high-risk of requiring post-hospital services, as identified through the screening process. Needs assessment data would then be used as the basis for post-hospital care decision-making and the development of the discharge plan (see Chapter 5).

## **Screening**

Screening refers to the process of reviewing a patient's characteristics according to predetermined criteria developed to identify those patients "at risk" of requiring post-hospital or extended care services. Generally, all patients are screened on admission to acute care facilities, with "high-risk" patients referred for a more intensive evaluation of their needs for continuing care. Recognizing that an intensive evaluation is not clinically warranted for all patients, screening attempts to maximize resources by predicting those patients most likely to need continuing care.

The changes in the health care delivery system (i.e., as evidenced by changes in patient acuity and case-mix, length of stay and practice patterns) that have occurred since implementation of the Medicare Prospective Payment System (PPS) have added new importance to the screening process. The literature is clear that patients with needs for continuing care must be identified early so that an appropriate discharge plan can be developed and implemented when the patient is medically stable (Terry, 1988; Cunningham, 1984; Rasmussen, 1984; Kitto & Dale, 1985). A number of studies have demonstrated that early case finding can reduce length of stay (Fagan, 1984; Rehr, Berkman & Rosenberg, 1980; Cunningham, 1982).

Traditional "high-risk" screening criteria have drawn upon patient characteristics such as age, diagnosis and living arrangements. The

---

literature demonstrates a gradual evolution in the sophistication of screening criteria, with an increased focus on nursing and other care requirements in current high-risk screening systems. Many facilities have made substantial modifications in their screening criteria over the past several years to incorporate the increasing number of patients that continue to require high-technology services in a post-hospital setting. Criteria typically used to identify patients that may require a needs 'assessment include:

- o Dependence in activities of daily living;
- o Age (over 65, especially those over 75);
- o Diagnosis with long-term consequences (e.g., cancer, stroke, chronic renal failure, diabetes, chronic obstructive pulmonary disease, congestive heart failure);
- o Living arrangements (lived alone or previous situation inadequate);
- o Admitted from another facility/level of care (i.e., nursing home, personal care home or community facility);
- o Decreased orientation and/or level of consciousness (e.g., comatose, lethargic, disoriented);
- o Nursing and other care requirements:
  - Medications (e.g., new to insulin injections, history of noncompliance, multiple medications/polypharmacy concerns);
  - Intravenous therapy (e.g., need for longterm antibiotics, hyperalimentation);

- Nutritional support (e.g., patients receiving enteral feedings);
  - Respiratory needs (e.g., ventilator dependence, tracheostomy care);
  - Wound or pressure ulcer care;
  - Care of tubes or other appliances (foley or suprapubic catheter, new colostomy or ileostomy, gastrotomy or nasogastric tube); and
- o Need for rehabilitative services (patient receiving physical, occupational or speech therapy) (Terry, 1988; Rasmusen, 1984).

While facilities generally incorporate some or all of the above factors in their screening programs, currently there is no universally applicable approach for determining which patients will benefit most from discharge planning (Hartigen, 1987). Experts believe that it would be difficult to establish uniform screening criteria. What may be an appropriate criterion in a rural area of the Midwest may be of no value in reviewing patients in an inner-city teaching hospital on the east coast. Facilities must generally tailor their screening programs according to the types and characteristics of patients they treat (P. Hanson, Panel presentation, September 27, 1988; J. Trachtenberg, Panel presentation, September 27, 1988).

A review of screening systems found in the literature and current practice demonstrates the divergent approaches utilized in various facilities. Techniques range in sophistication from simple checklists made up of a few "yes-no"

---

questions to algorithmic systems based on a comprehensive list of factors.’

### **Needs assessment**

Needs assessment refers to the process of evaluating the patient’s medical and functional status according to key factors that influence continuing care needs and the development of a viable discharge plan.<sup>2</sup> A patient’s present and projected medical status and care needs are evaluated in conjunction with the psychological, social, environmental and financial factors that will influence his or her ability to cope with continuing care needs (Rehr, 1986).

The literature yields little in terms of the utility, practicality or efficiency of needs assessment instruments developed for clinical use. In reviewing a number of instruments, Kitto and Dale (1985) found they could be categorized according to two types: extensive lists of patient characteristics predictive of discharge problems (a more fully developed screening system as discussed above) or checklists that combine a

review of patient characteristics or symptoms, functional status and data on the availability of family or other social supports and community resources utilized prior to admission. Ideally, needs assessment tools should facilitate the collection of patient information that is necessary to identify extended care needs and also be compatible with the diverse operational systems of various facilities (Kitto & Dale, 1985). The needs assessment instrument developed by the Panel is presented in Chapter 4.

### **Relationship of the needs assessment to the discharge planning process**

The needs assessment provides the foundation for the development of a discharge plan. Professional staff are responsible for performing a needs assessment prior to discharge. When needs are identified, the facility is obligated to develop and implement a discharge plan that addresses continuing care needs (see Chapter 6). Documentation should reflect that a

---

<sup>2</sup>Such a system was developed at Lafayette (Indiana) Home Hospital. A multidisciplinary process is used to identify high-risk individuals at the time of admission: patients are evaluated using comprehensive, weighted criteria, which are summed to provide a classification of “high”, “medium” or “low” risk for targeting of an appropriate level of intervention/referral. The system provides a mechanism for continuous updating, so that the patient’s risk factor status may change as his condition evolves. Use of the system is monitored through the hospital’s quality assurance program (Nice, 1989).

<sup>3</sup>The term “needs assessment” is used in the literature to refer to two different types of assessment processes. It applies to both a broad-based clinical evaluation to evaluate needs for continuing care as well as an evaluation to determine eligibility for specific services covered by a public program or third party payer. There may be differences in the nature, scope and process used to perform these two types of assessments, given the differences in their purposes. The discussion in this chapter focuses on needs assessment in the clinical setting by providers responsible for performing discharge planning. The use of needs assessment instruments to evaluate an individual’s eligibility for posthospital services is discussed in Chapter 7.

---

comprehensive assessment has been performed and referrals to appropriate post-hospital or long-term care providers completed (Simmons, 1986).

The sum of a number of components, discharge planning refers to a multi-faceted “interdisciplinary hospitalwide process that should be available to aid patients and their families in developing a feasible post-hospital plan of care” (American Hospital Association, 1984). In addition, discharge planning has increasingly been viewed as an activity that transcends acute care, or a “set of activities which facilitates the transition of the patient from one environment to another” (Society for Hospital Social Work Directors, 1985). Discharge planning activities are now more commonplace in nursing homes (Scheuermann, 1988) and home health agencies (Coleman, 1988); additionally, Federal requirements have begun to address post-acute care providers’ discharge planning responsibilities (see Chapter 6).

Needs assessment plays a critical role in the discharge planning process. While numerous definitions of discharge planning have been developed, a review of the literature reveals many central themes that point to a process of “identifying people in need, assessing their needs and the resources available to meet them, collaborating with other health care professionals as well as with the patient and family, and formulating and implementing a plan of action” (Blumenfield, 1986, p. 5 1).

## **B. ROLES AND RESPONSIBILITIES OF PROFESSIONALS INVOLVED IN ASSESSING NEEDS AND PLANNING FOR DISCHARGE**

Historically, the disciplines of medicine, social work and nursing have been intimately involved in the needs assessment process. Physicians, social workers and nurses have defined their discharge planning responsibilities in their respective standards of professional practice. The following summarizes the traditional roles of these professionals in terms of how they have viewed their unique contribution to discharge planning.

### **Physicians**

From both a clinical and legal perspective, the physician has always had a pivotal role in the discharge planning process. Responsibilities of the physician include writing the discharge order and discharge summary, prescription of necessary drugs and medical equipment, certification of the plan for home care (if indicated) and consultation with other professionals involved in discharge planning. Additionally, factors such as increased numbers of frail elderly, reimbursement pressures and the growth of multidimensional geriatric assessment technology have contributed to an expanded level of involvement in discharge planning activities for many physicians (Rubin, 1988; Hazzard, 1987).



---

Rubin (1988) supports the need for a more proactive role for physicians in the discharge planning process by discussing the following: 1) the physician is generally the identified continuing care provider and often the only professional who follows the patient through multiple levels of care; 2) the physician can facilitate participation in the needs assessment process and acceptance of the discharge plan in that the patient and family perceive the physician as the primary decision-maker and look to him or her for guidance; and 3) the physician alone has the authority to write orders and prescribe a therapeutic plan.

While physicians assume responsibility for the discharge plan, other professionals generally are responsible for assisting with its development and implementation. Both social workers and nurses have been identified in the literature as responsible for coordination of discharge planning activities.

### **Social workers**

Social workers point to their expertise in assessment and counseling, knowledge of systems and resources, and organizational skills to support a central coordinating role in discharge planning. Specific components of the social work role as defined by the American Hospital Association's Society for Hospital Social Work Directors include:

- o Development of systems which ensure timely and efficient identification of patients who require discharge planning;
- o Assessment of the psychological, social, environmental, and financial impact of illness on patients and families;
- o Provision of psychosocial services to patients and families;
- o Coordination of the contributions of the health care team;
- o Development and maintenance of liaisons with local, State and Federal resources;
- o Establishment of systems to monitor and evaluate the effectiveness of the discharge planning process; and
- o Identification of services which are available to meet the post-hospital needs of patients and families (1985).

The primary focus of the social worker's needs assessment is on social and emotional factors and the adequacy of resources in the community; the social worker examines whether the patient's **prehospitalization** living arrangements and routine will accommodate the prescribed medical treatment and nursing care (Lawrance, 1988).

### **Nurses**

Traditionally, the nurse has played a key role in the continuum of care, with the scope of

---

nursing practice directed toward assisting patients maintain or return to an optimal level of functioning that is consistent with limitations imposed by the aging process or the presence of acute or chronic conditions. In terms of needs assessment, the nurse contributes a holistic orientation and extensive knowledge of physical, psychological and social aspects of human growth and development, along with expertise in specific nursing interventions relative to identified areas of patient need (Griggs, 1987).

Fitzig (1988) describes nursing's contribution to the needs assessment as follows:

The nurse's ability to determine the functional level of the patient is instrumental in the development of a plan of care. The nurse's experience in the home and community enables her to assess the patient's and family's ability to respond appropriately to the identified needs. The nurse is able to determine what the patient is able to do and what other support staff can contribute to the patient's needs in the "normal" activities of living such as bathing, dressing, preparation of meals, and eating. The nurse... is able to give direct care and in addition, determine the gaps in services and make referrals to other disciplines (p. 95).

Clausen (1984) addresses the unique capabilities of the staff nurse, who is "available to the patient and family 24 hours a day, tracks every change in the patient's progress, ... (and assesses) what special skills and knowledge patients will need to function at their best in another setting" (p. 58). The staff nurse has a pivotal, yet sometimes underutilized role in discharge planning; in that he or she is in a prime position to

assess and intervene with complex or subtle problems that may have been missed by formal "screening" systems. Additionally, a nursing data base (i.e., admission assessment) is generated by a staff nurse for each patient and typically includes the following types of "needs assessment" data: health status, functional status, living environment, support systems and an evaluation of how well the patient has been coping at home (Clausen, 1984).

### **Potential for role conflict**

In performing a needs assessment, social workers have traditionally been viewed as having more expertise in social services, while the competencies of nurses are more in the physical domain. However, both the social worker and the nurse bring similar skills to the coordinator/case manager role (Griggs, 1987), and roles and responsibilities have often overlapped in some areas of needs assessment and discharge planning.

Although both disciplines acknowledge the need for the other's expertise, conflicts have surfaced over who should assume primary responsibility for coordinating discharge planning (i.e., the "turf" issue). However, with an increase in the types and volume of clinically complex situations that discharge planners now routinely address, spokespersons for both disciplines acknowledge that the other profession's skills are needed even more than previously and "there is

---

enough added responsibility to go around” (*Hospitals*, 1986, p. 108).<sup>3</sup>

Politically, the “turf issue” was not addressed in the OBRA 1986 provision that requires discharge planning to be performed by, or under the supervision of, a registered nurse, social worker or other appropriately qualified personnel (*Hospitals*, 1986).<sup>4</sup> Regulations restricting discharge planning or performance of the needs assessment to a particular discipline would not only be controversial and difficult to justify from a clinical perspective but also be an unnecessary hardship on facilities because of the wide variation in available resources and discharge planning systems across the country.

### **C. IMPACT OF THE REGULATORY SYSTEM ON THE EVOLUTION OF DISCHARGE PLANNING**

#### **Overview of historical efforts**

Though the Prospective Payment System has given discharge planning increased visibility and

importance, the practice of assessing continuing care needs as part of discharge planning dates back to the early 1900s. The first formal programs were initiated at Johns Hopkins Hospital (Baltimore) and Massachusetts General Hospital (Boston) in 1906, where physicians recognized that there is a relationship between a patient’s social environment and his illness. Medical social workers were hired to assess patients and provide information to the physician so that an appropriate medical treatment plan could be developed; social workers also counseled patients regarding environmental modifications necessary to attain or maintain optimal health (Lawrance, 1988). A similar program was implemented in 1907 at Bellevue Hospital (New York), using a nurse to assess patients and arrange for continuing care services (O’Hare, 1988).

Discharge planning responsibilities remained largely under the purview of the medical social worker and public health nurse through the 1950s (Volland, 1988). Prior to the introduction of the Medicare program and the Prospective Payment System in particular, discharge planning remained a relatively low priority for hospitals; the “real work” of patient care was viewed as completed

---

<sup>3</sup>Ideologically and organizationally, the “turf” issue looms as a potentially destructive factor capable of inhibiting collaborative discharge planning. However, in practice, most discharge planning systems function smoothly at the “grass roots” level through a dynamic process of interchange and cooperation between nurses and social workers. In a 1988 random survey of hospital discharge planning practices, most respondents reported little conflict between the two groups (Feather).

In a similar vein, the Panel examined a large number of discharge planning programs across the

country. Anecdotally, successful programs shared at least one attribute: regardless of the discipline assigned primary responsibility for discharge planning, there was a clear recognition and valuing of each discipline’s contribution to the process and a means (formal or informal) to capitalize on the “differences” between the professions through appropriate referral and consultation.

<sup>4</sup>The Panel drew upon the same philosophy in developing recommendations regarding the use of the needs assessment instrument (see Chapter 5).

---

by the point of discharge, with the final discharge documentation completed primarily for reimbursement purposes (Feather & Nichols, 1985).

### **Effect of Medicare program on discharge planning**

While the importance of discharge planning was recognized by clinicians in the early 1900s, discharge planning lacked visibility until it was legitimized by the public sector with the enactment of the Medicare and Medicaid programs in 1965 (Volland, 1988). The government's desire to expand access to necessary and appropriate services as well as assure their quality fostered the advancement of discharge planning services. Recent amendments to the Title XVIII and XIX programs have resulted in an environment where discharge planning and other continuity of care programs are viewed as critical underpinnings necessary for the integrity of the health care delivery system.

### **Efforts to contain rising health care costs**

The original Medicare legislation required the establishment of a utilization review committee in every hospital to review the appropriateness of services and lengths of stay. Growing Congressional concerns regarding the Federal government's burden to finance increasing Medicare program costs resulted in the passage of Public Law 92-603 in 1972, which created the Professional Standard Review Organization

(PSRO) program. PSROs were charged with monitoring: 1) the necessity and cost of services; and 2) that services were of a quality that met professionally recognized standards of care (Webber, 1988).

For example, necessity was reviewed in relation to the level of care that was indicated by the patient's medical status and care needs. If determined by the PSRO nurse and/or physician reviewer that the patient's care could be provided at home or in an extended care facility, all or part of Medicare reimbursement for hospital charges could be denied. This placed pressure on hospitals to discharge patients promptly and reinforced the need for effective discharge planning programs, which could facilitate discharge to the community or transfer to an extended care facility as soon as the patient's medical condition would allow. Early PSRO guidelines and the threat of financial sanctions for medically unnecessary hospital stays therefore encouraged the development of discharge planning systems and procedures within hospitals (O'Hare, 1988; Volland, 1988).

However, utilization review via the PSRO program was not successful as a cost containment measure. Efforts to refine the medical review process led to the enactment of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, which repealed the PSRO program and established the Peer Review Organization (PRO) program (Webber, 1988). Concomitant efforts to contain the dramatic rise in the Federal government's health care expenditures led to a

---

fundamental change in the Medicare program's method of payment for acute hospital services (Volland, 1988). The Social Security Amendments of 1983 (Public Law 98-2 1) ushered in the Medicare Prospective Payment System (PPS). Rather than reimburse hospitals on a cost-based retrospective system, this legislation changed the method of payment so that hospitals would be reimbursed prospectively, with rates based upon diagnostic related groups (DRGs). Reimbursement changes under PPS were phased in, beginning October 1983.<sup>5</sup>

The new Medicare payment methodology created added incentives for hospital providers to control costs and thereby focused additional attention on the need for effective discharge planning. A prime target of cost containment efforts was the elimination of medically unnecessary hospital days, which had the effect of increasing the provider's cost to render services. Under PPS, hospitals have a financial incentive to send patients home sooner, as reimbursement rates are based on diagnosis, rather than actual costs. Discharge planner's caseloads increased as the necessity of effective discharge planning to the financial well-being of hospitals was realized.

Discharge planning programs also received more visibility through a refocusing of regulatory quality assurance efforts, as the PROs' role in monitoring quality received increased attention after the implementation of PPS. Subse-

quent Congressional concerns regarding quality of care focused attention on the need to heighten quality review efforts and led HCFA to mandate application of generic quality screens to each case reviewed by the PROs as part of the second round of PRO contracts in 1986 (Webber, 1988).

Through this process, PROs began to examine a beneficiary's medical stability at the time of discharge as well as the adequacy of discharge planning (see Chapter 6). Additionally, the need for appropriate discharge planning was highlighted as a means of preventing unnecessary readmissions, one of the quality indicators reviewed by the PROs. Studies have shown that 40-50% of readmissions have been linked to social problems and lack of community services (Mason, Bedwill & Vanerzwaff, 1980; Andrews, 1986; Gooding & Jette, 1985; Graham & Livesley, 1983; Robinson, 1983).

While recent amendments to the Social Security Act have played a large role in creating the Congressional mandate to develop a uniform needs assessment instrument, a number of previous standards and regulations have also influenced the evolution of discharge planning practice.

### **Discharge planning standards and regulations**

Section 1861 of the Social Security Act stipulates that hospitals receiving reimbursement un-

---

<sup>5</sup>Much has been written on the establishment of the Prospective Payment System and the resultant effects on the health care delivery system, but a complete

discussion is beyond the scope of this report. An excellent overview is available in The impact of DRGs on the health care industry (Balinsky & Starkman, 1987).

---

der the Medicare program must meet certain requirements specified in the Act and that the Secretary of Health and Human Services (HHS) may impose additional requirements found necessary to ensure the health and safety of hospitalized Medicare beneficiaries. Accordingly, the Conditions of Participation, regulations setting minimum health and safety standards for Medicare participating hospitals, were promulgated in 1966 and substantially revised in 1986 (IoM, 1990).

The first Medicare Conditions of Participation for hospitals required discharge planning under the Social Service Condition. When the Conditions were revised in 1986, the Social Service Condition was deleted and social work and discharge planning requirements were moved under the Quality Assurance Condition at 42 CFR 482.21(b), standard: medically related patient care services. That requirement states:

The hospital must have an ongoing plan, consistent with available community and hospital resources, to provide or make available social work, psychological, and educational services to meet the medically-related needs of its patients. The hospital also must have an effective, ongoing discharge planning program that facilitates the provision of follow-up care. (1) Discharge planning must be initiated in a timely manner. (2) Patients, along with necessary medical information, must be transferred or referred to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

Changes in Federal discharge planning requirements were mandated by OBRA '86. Section 9305(c) provides additional structure and process standards regarding the screening process, discharge planning evaluation (i.e., needs assessment), and the development and implementation of the discharge plan. Proposed regulations were issued June 16, 1988 (see Chapter 6).

A number of States have recently enacted discharge planning legislation. A 1988 survey found that six states had passed such legislation while five others were considering bills or conducting preliminary investigations. There are wide variations in the legislative provisions that have been enacted, which range from a general requirement to have a discharge plan to detailed mechanisms and procedures for the discharge planning process. Other States have not enacted specific legislation but have added discharge planning to hospital licensure requirements.<sup>6</sup>

In many cases, new State requirements were the result of lobbying by senior citizens and other consumer groups (Discharge Planning Update, 1988).

There has also been a refinement of Joint Commission on Accreditation of Healthcare Organizations standards related to discharge planning over the years. The Joint Commission has traditionally addressed the discharge planning responsibilities of both social workers and nurses according to:

---

<sup>6</sup>As of late 1988, Arizona, California, Connecticut, Massachusetts, New Jersey and New York passed discharge planning related legislation; New York and Massachusetts are generally viewed as having the most prescriptive requirements. Arkansas, Florida, Iowa,

Mississippi and Virginia were considering legislation. States such as Maine and Washington added hospital licensure requirements pertaining to discharge planning (Discharge Planning Update, 1988).

- 
- o evaluation of the patient's needs and capacity for self-care;
  - o patient and family education;
  - o monitoring and evaluation of the discharge plan; and
  - o reassessment of discharge planning policies and procedures (Joint Commission, 1989).

Additionally, the increased importance of discharge planning is reflected in the augmentation of related standards under Management and Administrative Services (Joint Commission, 1989). The intent of the standards is to consolidate many of the requirements for specific services, with hospitals required to have hospitalwide policies and procedures for discharge planning (Nash, 1988).

Joint Commission requirements specify that an accredited hospital's policies and procedures must include methods for the early identification of patients who require discharge planning as well as specify the roles of the licensed independent practitioner responsible for the patient, other appropriate staff and the patient/family in the initiation and implementation of the discharge

planning process. The discharge plan, which contains an assessment of the availability of appropriate services to meet the particular patient's needs, must also be documented in the medical record (Nash, 1988).

Previous requirements related to discharge planning remain in effect to address department/service specific issues. New discharge planning standards became effective for accreditation survey purposes January 1988 (Nash, 1988).

Additional standards regarding discharge planning have been developed by the American Hospital Association's Society for Hospital Social Work Directors', the National League for Nursing' and the American Association for Continuity of Care.<sup>9</sup> Despite growth in the development of professional standards and regulations governing discharge planning, however, the potential for an incomplete or inappropriate evaluation of continuing care needs remains due to a lack of standardization in the content and administration of the needs assessment and discharge planning process.

---

<sup>9</sup>The Society for Hospital Social Work Directors (SHSWD) of the American Hospital Association (AHA) has contributed to the development of or authored a number of publications containing discharge planning standards or guidelines, including: Discharge Planning for Hospitals (AHA, 1974); Discharge Planning: Direct Patient Services (SHSWD, 1980); AHA Guidelines for Discharge Planning, (AHA, 1984); and The Role of the Social Worker in Discharge Planning: Position Statement (SHSWD, 1985).

<sup>8</sup>In August 1966, the Steering Committee of the National League for Nursing (NLN), Division of Nursing Services, issued one of the first sets of recommendations regarding continuity of nursing care (O'Hare, 1988).

<sup>9</sup>Discharge planning standards of practice were developed by a committee of the American Association for Continuity of Care (AACC) and approved by the general membership in December 1986 (O'Hare, 1988).

---

## D. VARIATIONS IN DISCHARGE PLANNING PRACTICES

Much variation in discharge planning systems and practitioners exists across the country. The following provides a brief look at the diversity found in clinical practice.

### Overview of current discharge planning systems

Lead responsibility for discharge planning has generally shifted between the nursing and social work professions, with the following models of discharge planning systems traditionally found in practice settings:

- o Physicians and nurses assess needs for post-hospital care, with implementation of the discharge plan by a discharge planner;
- o Unit-based social workers collaborate with staff nurses to identify needs for post-hospital care, with responsibility for implementation of the plan based on the type of care needed (e.g., nurses arrange for home care, social workers arrange for nursing home care);
- o Physicians and nurses assess needs, with referral to the social worker who assumes responsibility for addressing needs (e.g., arranging transportation or nursing home referral, consultation with patient and/or family); and

- o A designated discharge planner, usually a nurse, assumes responsibility for continuity of care activities (i.e., functioning relatively autonomously, the discharge planner screens patients, performs a needs assessment, develops and implements a discharge plan) (Reichelt & Newcomb, 1980).

Increasingly, there has been a transition towards a more comprehensive and multidisciplinary approach to discharge planning. Generally recognized as the preferred approach, this model draws upon the knowledge and expertise of all appropriate health professionals to identify and meet the, post-hospital needs of patients. Physicians, nurses, social workers, therapists, dietitians and other professionals identify needs, while the social worker is responsible for identifying and arranging for appropriate services (McNulty, 1988).

Regardless of whether multidisciplinary participation in discharge planning is an expectation of the facility, the various disciplines bring unique expertise to the needs assessment. Though physicians, nurses and social workers have generally taken the lead in discharge planning, appropriate disciplines (e.g., dietitians, physical or occupational therapists) should be consulted, depending on the specific needs of the patient. Zarle (1988) views a coordinated, multidisciplinary approach to discharge planning as a basic patient right and underscores the need for professional recognition and valuing of other health care disciplines necessary for the process.



---

The majority of current discharge planning programs could probably be classified under one of the above models. However, program characteristics are affected by several factors, including the size and geographical location of the hospital, as well as the staff organization, the case-mix of patients and the number and type of resources available in the community. Modifications and adaptations are particularly prevalent in small or rural hospitals, where a staff member may be the designated discharge planner in addition to performing a number of other responsibilities; for example, the rehabilitation therapist may be assigned responsibility for discharge planning as a part of his or her more traditional patient care responsibilities (McNulty, 1988).

Secondary to the environmental forces that heightened the importance of discharge planning, there has been a dramatic increase in discharge planning activities at most hospitals during recent years. Preliminary results from a three year study <sup>10</sup> revealed that 56% of discharge planners reported that discharge planning services have been added since 1984; 73% of hospitals reported instituting new discharge planning policies or procedures since the implementation of Prospective Payment; and 96% of hospitals reported an increase in the workload of discharge

planning staff. However, 49% reported that the number of discharge planning staff had either remained the same or decreased since 1984 (Institute for Health and Aging, 1987).

Other changes in organizational structures reflect the trend towards specialization. Most facilities still house responsibility for discharge planning in the social services department. Survey results from 1987 indicate that responsibility for discharge planning rests with the social services department for 72% of respondents. Other departments assigned responsibility for discharge planning include: patient services, 7%; discharge planning, 5%; nursing, 1%; and other, 15% (Institute for Health and Aging).

However, an increasing number of facilities are moving towards formalizing multidisciplinary participation by creating separate discharge planning or continuity of care departments, which generally consist of teams of nurses and social workers that specialize in discharge planning. Other facilities combine resources to perform related functions and house responsibility for discharge planning in an administrative department such as quality assurance, utilization review, risk management or admissions (O'Hare, 1988).

The nation has also witnessed the evolution of discharge planning specialists/coordinators

---

<sup>10</sup>This three year multicomunity study was conducted to examine the effects of Federal and State medical care cost containment policies, in particular the Medicare Prospective Payment System, on organizations that deliver health and social services to the elderly. This study was

undertaken by researchers at the Institute for Health and Aging of the University of California, San Francisco, and was funded by the Pew Memorial Trust, the Robert Wood Johnson Foundation and the Fred Meyer Charitable Trust.

---

as well as the emergence of specialization within discharge planning.” In a 1988 survey of hospitals, 51% had personnel whose only responsibility was discharge planning (Feather).

Organizationally, the concept of discharge planning has undergone a change in its emphasis to reflect a greater concentration on providing for “continuity of care,” with hospitals beginning to operate more on a continuing care model rather than exclusively on an acute care model.<sup>12</sup> For patients with chronic health problems, a hospitalization is viewed as one in a series of episodes in the patient’s “care trajectory;” such patients require assistance to facilitate movement to appropriate levels of care along the health care continuum (R. Kane, Panel presentation, August 3, 1988).

Two models exist to characterize the provision of continuity of care. Patient needs can be categorized into two different groups: 1) short-term/long-term care (STLTC) refers to those patients who require temporary support; 2) long-term/long-term care (LTLTC) refers to those in need of permanent or extended support (Brody & Magel, 1984).

---

<sup>12</sup>For example, specialization within the field of discharge planning has occurred, with some discharge planners focusing on particular patient populations, such as oncology, AIDS, Alzheimer’s Disease and other dementias, etc. Other discharge planners concentrate on particular aspects of discharge planning as dictated by the needs of their employers, which have expanded to include Health Maintenance Organizations (HMOs), case management firms, and third party payers. Other discharge planners work in non-traditional settings, such as the community and long-term care settings.

“This movement was facilitated by the increase in vertical integration of services that occurred after the implementation of PPS. Entry into community or institutionally based long-term care began to provide many

Discharge planning plays a key role in addressing short term problems, with Medicare and commercial insurances providing the major sources of funding. Case management services play a larger role in addressing long term needs, as evidenced by experiences with social/health maintenance organizations (SHMOs) and channeling demonstration projects. Financial support for such services is more limited and is primarily reimbursed through Medicaid and private pay (Volland, 1988).

Increased attention to the establishment of linkages across various types of care settings is necessary for the development and utilization of appropriate post-hospital services and resources (O’Hare, 1988). A number of hospitals have responded to this challenge. However, at the other end of the spectrum, some facilities, especially those in rural or isolated areas of the country, report a limited availability of post-hospital services and/or difficulties in arranging access to post-hospital services. A GAO study found that few discharge planners report having no problems in arranging access to post-hospital care for Medicare beneficiaries.

hospitals with a much needed source of operating revenue to replace their shrinking in-patient income. Services such as private duty home nursing, home pharmacy and durable medical equipment were particularly attractive to organizations seeking a vertically integrated continuum of care. From a marketing perspective, such a coordinated care system could also assist the facility in maintaining their patient base, rather than losing clients after discharge to a more traditional post-acute care provider.

A number of hospitals have elected to either create or purchase a program/facility or to enter into a partnership with a community agency. Discharge planning systems, therefore, have taken on increasing importance as a means to capitalize on the utilization of necessary posthospital services.

---

More than half of the discharge planners responding to a nationally representative survey reported that access to necessary post-hospital services was more limited in 1985 than 1982, with an increase in the number of patients experiencing prolonged hospitalizations secondary to the need to wait for appropriate placement (GAO, 1987).

### **Preparation of discharge planners**

Recent surveys provide additional information regarding discharge planners that elucidates the lack of standardization regarding the preparation of discharge planners. Results from a 1987 survey indicate that most designated discharge planners are social workers,<sup>13</sup> although 8 1% felt they functioned as a member of an interdisciplinary patient assessment and monitoring team (Institute for Health and Aging, 1987). Another survey of 548 randomly selected hospitals in 1988 found that discharge planning is primarily a “learn

as you go” occupation, with only 35% of respondents having special training in discharge planning when they assumed their responsibilities (Feather).<sup>14</sup>

A review of the literature reveals the extensive knowledge required to perform discharge planning. Common threads required by discharge planners, regardless of their professional background, include the ability to perform a needs assessment, develop and implement a discharge plan and knowledge of post-hospital resources. More specifically, physical assessment skills and clinical knowledge regarding care needs are important as is knowledge of psychosocial assessment and counseling skills (Poe, 1990), though actual knowledge, abilities and interest around these areas are often dependent upon the individual discharge planner.<sup>15</sup>

Discharge planners must remain abreast of current and proposed legislation as well as regulations affecting discharge planning. They also require a good understanding of public and third

---

<sup>13</sup>As reported through the survey, 17% of discharge planners were registered nurses, 1% licensed practical nurses; 64% Master’s level social workers; 11% Bachelor’s level social workers; and 7% other personnel.

<sup>14</sup>Despite the increasing body of knowledge needed by discharge planning professionals, very few colleges or universities currently offer programs or coursework related to discharge planning. One new and innovative program is the Continuity of Care Nurse Specialist Project in the Graduate School of Nursing at the Catholic University of America (A. Cary, personal communication, June 1989).

However, a number of continuing education programs are available for discharge planners, many of which are offered on an annual basis, such as the National Institute

for Discharge Planning and Continuity of Care (a week long intensive seminar) and the American Hospital Association’s Society for Hospital Social Work Director’s Annual Discharge Planning Symposium.

<sup>15</sup>A debate regarding whether there is a body of knowledge necessary to perform discharge planning has occurred within the field for at least the past five years. The development of a certification exam for discharge planners was first proposed by then American Association of Continuity of Care (AACC) President Agnes McBroom in 1985, but tabled due to a lack of interest by the membership (Poe, 1990). AACC is again exploring certification and has appointed a Committee to spearhead the development of a certification examination (J. Feather, personal communication, June 1990).

---

party payer funding mechanisms and eligibility criteria, as knowledge of benefits and resource limitations dramatically affects the development of viable options for post-hospital care. Additionally, they must be knowledgeable regarding the availability of services and other resources available from Federal, State and local programs as well as religious, private and other community resources (McCarthy, 1988).

Skills required in the discharge planning role include: teaching ability, verbal and written communication skills, flexibility and assertiveness (McCarthy, 1988). Good interpersonal skills are necessary to work effectively with patients, families and other members of the health care team. Also paramount is the ability to coordinate the decision-making process and its related documentation as well as navigate the complex organizational environment and community system in which discharge planning occurs.

A recent study of complications in discharge planning with Medicare patients underscores the complexity of discharge planning and highlights the importance of professional skills in address-

ing problems routinely encountered in the discharge planning process (Proctor & Morrow-Howell, 1990).<sup>16</sup> In this study, at least one complication occurred in 61% of cases, with 37% experiencing two or more complications. The scope of knowledge and sophistication needed to perform discharge planning is apparent, given the myriad of skills and abilities necessary to coordinate communication and decision-making among patients, families, medical staff, community services and reimbursement sources. Yet, effective discharge planning requires more than textbook knowledge, as planners must be responsive to each individual's unique needs and support structure, as well as routinely deal with new problems and an evolving health care delivery system.

### **Relevant issues for implementation of a uniform system of needs assessment**

The wide variation in the state-of-the-art must be considered when formulating recommendations regarding needs assessment and the discharge planning process. Facilities dictate

---

<sup>16</sup>Proctor and Morrow-Howell defined complications in discharge planning as impediments which posed an obstacle to the course of planning for posthospital care. Complications encountered in discharge planning were categorized according to: financial impediments; patient confusion or dementia making decision-making difficult; lack of family availability; difficulties in working with the patient or family (patients who would not participate in discharge planning, did not follow suggestions or requests or would not consider posthospital care options; family members who were indecisive or unwilling to engage in planning); unexpected medical developments; Medicare or

Medicaid guidelines (coverage restrictions or lack of clarity about covered services); lack of communication among team members; family disagreement/conflict; transportation problems; team disagreement regarding the patient's psychosocial situation and/or care needs; forms not completed in a timely fashion (e.g., hospital, third-party or discharge destination forms); delay in targeting discharge date; professional workers unavailable (other hospital or community professionals were not available for consultation or completion of arrangements); and other complications, such as necessary services that were not available (1990).

---

responsibility for discharge planning in a number of ways and there are numerous possibilities regarding the interrelationships of the various disciplines involved in the discharge planning process. Operationally, there may or may not be a designated discharge planner available to perform a needs assessment and follow through with the development and implementation of the discharge plan. Responsibility for the needs assessment may be assigned to a department whose staff has numerous other functions or to a multidisciplinary team. Clearly, a uniform needs assessment instrument must be capable of accomodating these diverse operational systems and of use by various disciplines and professionals with divergent backgrounds and levels of expertise (J. Trachtenberg, Panel presentation, September 26, 1988; P. Hanson, Panel presentation, September 26, 1988).

Little standardization has existed in discharge planning programs, practitioners and processes. Lack of standardization does not necessarily imply a problem. Facilities must retain the ability to develop discharge planning programs that: 1) from a clinical perspective, address the unique needs of their patient population; and 2) from a management perspective, make the best use of available resources. As such, some aspects of the discharge planning process are not amenable to standardization.

However, safeguards to ensure the appropriateness and quality of care provided to patients are necessary and have long been a part of the Medicare program. The potential for deficits in

necessary post-hospital care and poor patient outcomes increased with the introduction of the Prospective Payment System; hence the impetus for the development of a uniform needs assessment instrument.

#### E. ENVIRONMENTAL FACTORS

The regulatory system has clearly played a major role in influencing the evolution of the health care delivery system and enhancing the importance of discharge planning. Concomitantly, other environmental factors have highlighted the need to focus attention on transitional care issues and develop mechanisms to ensure the provision of appropriate post-hospital services.

#### **Changes in provider practice patterns and case-mix**

The impact of PPS on acute care lengths of stay (LOS) and provider practice patterns has been well documented. The subsequent reduction in hospital lengths of stay after the introduction of PPS has meant that the discharge planning process became more concentrated, with less time available to identify and plan for continuing care needs. Additionally, there has been an increase in the complexity of post-discharge care needs, with discharge plans now required for many sub-acute problems (i.e., to address needs for skilled or supportive care) that may previ-

---

ously have been resolved prior to discharge.

For example, studies have shown that patients are now discharged from acute care with higher levels of functional dependency (Coe, Wilkinson & Patterson, 1986; Guterman & Dobson, 1986; Berenson & Pawlson, 1984). Prior to PPS, beneficiaries may have remained in the hospital for a few additional days to regain strength after surgery or a debilitating illness; with shorter lengths of stay after the introduction of PPS, patients' needs for supportive assistance increased after discharge. Additionally, the provision of much skilled care shifted to sub-acute or community settings, which increased discharge planners' responsibilities in arranging for care (e.g., such as arranging for home health agency services for the administration of long courses of intravenous (IV) antibiotics). Altogether, this has further underscored the importance of operating an effective discharge planning process (O'Hare, 1988).

### **Expansion of post-hospital services-response to changing incentives**

A number of factors have spurred the expansion of post-hospital services.<sup>17</sup> Changes in Medicare coverage criteria for post-hospital services in the early 1980s increased the number of providers offering post-hospital services as

well as service utilization rates. For example, in July, 1981, home health agency benefits were liberalized to remove the limit on number of visits and prior hospitalization requirements (Barhydt-Wezenaar, 1986).

The advent of PPS, with its stimulus to shift care from the acute care hospital to alternative settings, also fostered the development of post-hospital services. An increasing number of acute care facilities began extending their traditional concentration on inpatient services to encompass a comprehensive range of health care services. The development of "alternative site" programs and services was driven by the need to reduce hospital costs and enhance revenue as well as the use of other marketing strategies designed to capitalize on the incentives associated with PPS. Home health agencies and hospital-based skilled nursing facilities were often designed to meet the needs of the "high tech" discharge. Such programs offered hospitals a sub-acute care alternative for the provision of services such as IV antibiotics, chemotherapy, Total Parenteral Nutrition (TPN), naso-gastric tube feedings and care of individuals requiring artificial ventilation via a respirator. Providing such care in the home or in a skilled nursing facility could reduce a number of days from the hospital stay of a Medicare patient, thus turning a financial loss under PPS into a potential gain.

---

<sup>17</sup>A complete discussion of trends in the utilization of posthospital services by Medicare beneficiaries is beyond the scope of this report. Gornick and Hall (1988) provide an excellent discussion of skilled nursing facility,

home health agency and inpatient hospital rehabilitation benefits under the Medicare program and the use of these benefits after a hospital stay.

---

Other traditional in-patient services have shifted to ambulatory care settings. There has been a dramatic increase in the utilization of ambulatory surgery centers and the types of procedures now routinely performed as an outpatient. This also has impacted on the number and variety of beneficiaries' needs for after-care during convalescence. For example, while cataract surgery may be performed safely on an outpatient basis, the patient may be discharged home immediately after surgery requiring additional assistance for several days. The scope and type of the assessment done prior to discharge to the community varies considerably, with the beneficiary at risk if needs are not appropriately identified and planned for, particularly if no informal support is available to assist in coping with incapacities resulting from the surgery.

### **Advances in medical technology**

Continual advances in medical technology reinforced the need for more sophisticated systems to prepare patients for frequently complex post-hospital care regimens. Growth in life-sustaining technologies and surgical procedures such as total hip replacement, cardiac bypass and organ transplantation, as well as the expanded use of infusion therapies, including IV antibiotics, chemotherapy, TPN and other medications delivered intravenously through continuous or periodic infusion, have reinforced the need to identify and plan for continuing care needs early

during the course of hospitalization. By shifting the use of such technologies to post-acute care settings, thorough assessments to determine an individual's care needs and the availability of family and community support services have become even more critical to the ultimate rehabilitation, convalescence and safety of the individual after discharge to the community.

### **Effect on provision of discharge planning services**

A decrease in length of stay means that professional staff have less time to complete the discharge planning process (i.e., target patients in need of discharge planning, perform a needs assessment, and develop and implement a discharge plan). There is less time available to educate individuals and their families regarding self-care activities as well as to generate referrals for necessary services. While programs strive to increase their efficiency, there are limits to how much the discharge planning process can be shortened and still provide an accurate assessment of continuing care needs and arrange for an appropriate discharge plan. Additional resource constraints (such as decreases in program budgets secondary to institutional downsizing or cost-containment measures) create yet another hardship for discharge planning professionals.

Stressors on the discharge planning process are summarized as follows:

Hospitals have been buffeted by major changes in their internal operating envi-

---

ronment. Efforts to identify and to correct problems are complicated by the shrinking length of stay, a higher patient acuity level, staffing shortages, rapid turnover of employees and the increasing use of part-time and hourly workers. ... In addition, the hospital is increasingly subject to external, community factors that can dramatically affect how and how well it operates. For example, the urban hospital has been stressed by AIDS, the drug epidemic with its related trauma, premature births, child abuse, lack of long-term care beds, abandonment of elderly dependents, increasing numbers of uninsured patients, and growing numbers of non-English speaking patients. Hospital efforts are also complicated by the absence of an integrated insurance program for the elderly that covers both acute and long-term care beds. This encourages discontinuity of care and communication gaps across settings of care that affect both the quality and efficiency of care (IoM, 1990, p. 245).

Thus, environmental factors both complicate the discharge planning process and detract from the clinician's ability to perform an adequate needs assessment. Yet, these same environmental factors underscore the critical nature of the needs assessment in ensuring that diverse and complex continuing care needs are appropriately identified and provided for.

### **Evaluation of the adequacy of discharge planning:**

Most studies of discharge planning have focused on issues surrounding the discharge planning process, such as efficiency. Little research

has been done to evaluate the effectiveness of this process or the adequacy of discharge plans. Adequacy of discharge planning can be assessed in terms of the plan's ability to meet both medical and psychosocial needs at the time of discharge as well as the plan's appropriateness in meeting needs over time.

A recent study by Morrow-Howell, Proctor & Mui revealed that over 70% of a sample of plans were rated as good or excellent to meet medical and psychosocial needs at discharge. However, over 25% of Medicare patients were discharged with plans rated barely adequate or worse, suggesting a sizable number of beneficiaries at risk after discharge (in press).<sup>18</sup>

Additionally, little is known about the long-range effects of discharge planning. Most hospital-based discharge planning programs do not follow individuals after discharge to evaluate the effectiveness of discharge plans in meeting an individual's medical and psychosocial needs. An evaluation of the appropriateness of discharge plans can only be made indirectly based on information about readmission rates. A GAO study contended that, although critically important, the relationship between discharge planning and patient outcomes remains unclear and warrants additional investigation, particularly for various patient types (i.e., in terms of age, diagnosis and level of functional dependence) and discharge destination (1986).

---

<sup>18</sup>Proctor & Morrow-Howell are currently studying the adequacy of community-based care plans for chronically ill Medicare beneficiaries discharged from acute to home care, under a grant from the Public Health Service's

Agency for Health Care Policy and Research (study abstract); N. Morrow-Howell, personal communication, June 1990).



---

## **Summary**

Despite growth in professional standards and regulatory requirements, there remains a lack of standardization in needs assessment and discharge planning services. The importance of programs and systems to foster continuity of care has received a great deal of recognition. However, the rising acuity of patients receiving care, as well as epidemiological changes in the case-mix of patient populations (i.e., as evidenced by an increased incidence of chronic, terminal and disabling illnesses), have pointed to the need for increasingly knowledgeable discharge planning professionals and sophisticated systems to promote coordination of post-acute care service provision.

## **F. CONGRESSIONAL CONCERNS REGARDING THE ADEQUACY OF DISCHARGE PLANNING FOR THE POST-HOSPITAL NEEDS OF PATIENTS**

The uniform needs assessment initiative was one of a number of OBRA 1986 provisions under the general heading “Improving Quality of Care

with Respect to Part A Services.” It was enacted during the height of public concern surrounding the effects of the Medicare Prospective Payment System,<sup>19</sup> despite the provider community’s claim that there was no hard evidence to support charges that hospitals were discharging patients too early or that there were serious quality of care problems (Discharge Planning Update, 1988).

The impetus for this legislation began in February 1985 as a result of a GAO report<sup>20</sup> and Senate Special Committee on Aging investigation, which found that Medicare beneficiaries were being discharged, or had the potential to be discharged “quicker and sicker,” and to inappropriate levels of care (B. Fuchs, Panel presentation, June 1, 1988).

## **Senate Aging Committee’s Quality of Care Hearings**

During the fall of 1985, a series of hearings was held by the Senate Special Committee on Aging in response to concerns regarding the impact of DRGs on the quality of care received by Medicare beneficiaries. Chaired by Senator John Heinz, The Quality of Care Under Medicare’s Prospective Payment System

---

“The literature has long reflected concerns regarding the vulnerability of patients, particularly the elderly, who are discharged from the hospital; the introduction of PPS only served to heighten concerns (Waters, 1987; Newcomer, Wood & Sankar, 1985). One problematic issue concerns “care gaps” (Senate Special Committee on Aging, 1986), which result from “systems” problems in the coordination of care between the hospital and home care agencies (Frasca & Christy, 1986) or lack of coordination among services supplied by various providers.

“Senator John Heinz (R-Pa), as Chairman of the Senate Special Committee on Aging, requested the General Accounting Office conduct a study on the information needed to assess the impacts of the Medicare Prospective Payment System (PPS) on posthospital long-term care. Key issues addressed in the GAO report included: 1) Have patients’ posthospital care needs changed?; 2) How are patients’ needs being met?; 3) Are patients having access problems?; and 4) How have long-term care costs been affected? (GAO, 1985).

---

hearings<sup>21</sup> focused on problems in hospital discharge planning and the appropriateness, availability and quality of post-hospital services (Senate Special Committee on Aging, 1986).

A Committee staff report and testimony given before the Committee on September 26, 1985, contended that “seriously ill Medicare patients are inappropriately and prematurely discharged from hospitals” (Senate Special Committee on Aging, 1986, p. 319). Testimony to the Committee reflected the diverse yet compatible concerns of both providers and recipients of care; themes underlying testimony focused on the need for safeguards to facilitate the transitional process to post-hospital care and ensure that continuing care needs are appropriately identified and addressed prior to discharge (Senate Special Committee on Aging, 1986).

The following problems were alleged during the course of the hearings:

- o Under PPS, large numbers of Medicare patients who continued to require heavy medical care were discharged from hospitals into their communities for care.
- o Home health and nursing home care were often unavailable or substandard in many communities.
- o Hospital discharge planning-the only mechanism available to ensure patients are placed in appropriate community

settings”- was seriously taxed under PPS and often failed to identify and provide adequate services for Medicare patients (Senate Special Committee on Aging, 1986, pp. 339-340).

To assist in addressing these complex problems, staff recommendations called for:

- o Upgrading of Federal rules for hospital discharge planning, to include pre-discharge consultation between all professionals giving care to the patient, and informing beneficiaries, prior to discharge, of their entitlement to Medicare and Medicaid post-hospital benefits and their rights of appeal; and
- o Restructuring of Medicare’s eligibility determination and appeals process, with adoption of a uniform needs assessment tool for post-hospital benefits, based upon patients’ functional abilities (Senate Special Committee on Aging, 1986, p. 342).

An investigator for the Committee shared his remembrances of issues that provided the impetus for the uniform needs assessment initiative with the Panel:

We did find evidence of poor quality discharge planning services in many hospitals, particularly rural hospitals. We found instances where people have very little in the way of formal background and train-

---

<sup>21</sup>The initial Quality of Care hearings consisted of: 1) Medicare DRGs: Challenges for Quality Care, September 26, 1985; 2) Medicare DRGs: Challenges for Post-Hospital Care, October 24, 1985; 3) Medicare DRGs:

The Government’s Role in Ensuring Quality, November 12, 1985 (Senate Special Committee on Aging, 1986). Additional hearings focusing on nursing home and home health care were held Spring, 1986.

---

ing, who were being put in a very difficult position, fulfilling this critical function in the hospital. ... There was ample evidence that discharge planning services might benefit from having at least a certain core minimum information at the disposal of the discharge planning personnel, when planning the services, or when deciding whether to (initiate a discharge) plan. ... (Additionally) providers out there everywhere were developing their own needs assessment instruments (home health care providers, nursing homes, various levels of government); there are many, many, many instruments out there. ... It seemed clear that with this wide variety of instruments ... that providers were seeing the need for it ... (and might appreciate) an acceptable uniform document that met their needs. ... Any provider might augment a uniform instrument because of their own special needs in their community, but if there was a uniform basic minimum data set that got all the essential information ... we thought that would be very helpful, and we got that kind of feedback from providers (D. Schulke, Panel presentation, June 1, 1988, transcript pp. 53-55).

Congressional interests driving the uniform needs assessment initiative included the following:

(We) ... hope that it will improve the relevance and accuracy of eligibility determinations for Medicare home health and skilled nursing facility services. ... (We) hope this will form a core of necessary information for discharge planning, specifically information necessary to make that evaluation, which is required in law

... in the same clump of statutory provisions that we know as the Quality Assurance Provisions of '86, specifically the discharge planning evaluation as required by Section 9305(c). ... (We) hope that a uniform needs assessment instrument will help coordinate the planning and care of patients who are moving through the system quite separately from hospital in-patient care. That is, (for example, those patients who) ... may go from home to home health, and back to home. ... In other words, this could form the conceptual basis and technical basis for figuring out how to pay for services based on patient needs rather than where they got the care. ... (D. Schulke, Panel presentation, June 1, 1988, transcript pp. 55-58.)

### **Enactment of OBRA '86**

The uniform needs assessment provision was incorporated in the Medicare Quality Protection Act of 1986 (S. 233 1 and H.R. 4638), introduced by Senator John Heinz and Congressman Pete Stark. The legislation had widespread bipartisan support as well as support from a number of consumer associations and provider groups (B. Fuchs, Panel presentation, June 1, 1988).<sup>22</sup> It was incorporated in the Omnibus Budget Reconciliation Act of 1986, with a conference report filed October 17, 1986 (Conference report to accompany H.R. 5300, 1986).

Section 9305 of OBRA '86 included a num-

---

<sup>22</sup>In the mid-1980s, a broad-based coalition of such groups formed around discharge planning issues. The coalition included the American Hospital Association's Society for Hospital Social Work Directors, American Association of Retired Persons, American Nurses' Association, American Organization of Nurse Executives, National Association of Social Workers, National

Association for Home Care, and American Association for Continuity of Care. The coalition drafted language for the Discharge Planning Condition of Participation for hospitals that was mandated by OBRA 1986. It was formally submitted to HCFA in June 1987, for consideration in developing the regulation (HCFA, Health Standards and Quality Bureau files).

---

ber of other provisions in addition to the requirement for the development of a uniform needs assessment instrument:

- o Development of a legislative proposal to refine the Prospective Payment System, in order to improve the classification and payment system (Subsection a);
- o Requiring notice of hospital discharge rights (Subsection b);
- o Requiring hospitals to provide discharge planning as a Condition of Participation (Subsection c);
- o Study of the Medicare Conditions of Participation for their adequacy in assuring the quality of inpatient hospital services (Subsection d);
- o Study of payment for administratively necessary days (Subsection e);
- o Extension of waiver of liability provisions to hospice programs (Subsection f)
- o Extension of waiver of liability provisions to certain coverage denials for home health services (Subsection g);
- o Inclusion of information on quality of post-hospital care in annual reports on prospective payment system (Subsection i); and

- o Study of prior and concurrent authorization for Medicare post-hospital extended care and home health services through a demonstration project (Subsection k).

### **Continuing focus on post-acute care issues**

Congressional concerns regarding the adequacy of post-hospital care for Medicare beneficiaries continued after the passage of OBRA '86. A 1989 report by the Committee on Government Operations, "Quicker and Sicker: Substandard Treatment of Medicare Patients," reiterated many of the concerns that originally surfaced during the Quality of Care Hearings. The report recommended that HCFA:

begin an intensive review of the post-hospital care given Medicare patients to determine the adequacy of facilities and treatment, and for the purpose of recommending to the Congress measures to improve the effectiveness and resources of care after discharge (p. 27).

Per the OBRA '86 mandate, HCFA has also been reporting to Congress annually on the impact of the Prospective Payment System and quality of care issues (Eggers, 1987). Additionally, a number of HCFA studies are underway to examine the availability and adequacy of post-hospital services.<sup>23</sup>

---

<sup>23</sup>Studies funded by HCFA to examine posthospital and other transitional care issues are summarized by Gornick

and Hall (1988) and in the Status Report of Research and Demonstrations in Health Care Financing (1988).

---

## G. ISSUE TO ADDRESS: LACK OF STANDARDIZATION IN THE NEEDS ASSESSMENT PROCESS

This chapter has explained the role of the needs assessment in the discharge planning process. By examining pressures associated with the evolving health care delivery system, it has also demonstrated the importance of an accurate and appropriate needs assessment in developing a plan to meet the increasingly complex continuing care needs of an aging population.

The need for a standardized needs assessment process has long been discussed in the literature and by practitioners in the field (see Chapter 3). Supporters of this concept advocate the inclusion of certain critical items in every needs assessment, with a uniform needs assessment instrument serving as a safeguard to ensure that needs are consistently and accurately assessed.

Lack of standardization of the terms and scales used to assess patients' needs also contributes to difficulties in communicating needs across care settings, as there is no consistent way to transfer patient care information to continuing care providers. Vladeck (1987) summarizes the need for uniformity in building a continuum of care as follows:

... common records or shared data systems, while they smack of dull, bureaucratic routines, are also essential. What is required, after all, is not just a set of shared

procedures or forms, but the creation and maintenance of a communications system and a common language among all of those involved in providing care to the client. Without such a system and such a language, the client is at considerable risk of being pushed or pulled in one direction by the right hand and the opposite direction by the left, which will result in going around in circles. .. (p. 9).

Provider support for the development of a uniform needs assessment instrument is best summarized by Kitto and Dale (1985), who in surveying patients about to be discharged from an acute care facility, found that many had substantial numbers of continuing care needs. They felt that patient care and staff productivity was hindered by lack of a "uniform way to assess these needs" (p. 28).

In developing a uniform needs assessment instrument, there is a need to balance a number of concerns. By providing a core set of critical items upon which to base the needs assessment, adoption of a uniform needs assessment instrument would serve as a clinical standard to ensure the quality of care provided to beneficiaries. However, in designing a uniform system of needs assessment, providers must be allowed sufficient flexibility to individualize the process based upon their own distinct capabilities, case-mix and resource limitations. Additionally, the system must also be feasible for use in a variety of settings. This conflict is addressed by Robert Kane:

There is an inevitable battle around any minimum data set between those who view it as an opportunity to find out all they ever

---

wanted to know about the subject but were afraid to ask, and those who recognize that less can often produce more when streamlined approaches reduce respondent burden (1990, p. 291).

The following chapter will discuss issues in clinical assessment for post-hospital care decision-making and present an overview of relevant assessment methodologies studied pursuant to the development of the uniform needs assessment instrument.

---

## References

- The Advisory Panel on the Development of Uniform Needs Assessment Instrument(s): Verbatim transcript of the first meeting. Washington, D.C., June 1-2, 1988.
- American Hospital Association. Discharge planning for hospitals. Chicago: American Hospital Association, 1974.
- American Hospital Association. Guidelines: Discharge Planning. Chicago: American Hospital Association, 1984.
- Andrews, K. Relevance of readmission of elderly patients discharged from a geriatric unit. Journal of the American Geriatrics Society, 1986, 34, 511.
- Around the nation: Discharge planning legislation. Discharge Planning Update, November-December 1988, 8 (6), 5-8.
- Balinsky, W. & Starkman, J. The impact of DRGs on the healthcare industry. Health Care Management Review, Summer 1987, 12 (3), 61-74.
- Barhydt-Wezenaar, N. Home care and hospice. In S. Jonas (Ed.), Health care delivery in the United States (3rd Edition). New York: Springer Publishing Company, 1986.
- Berenson, R. & Pawlson, L. The Medicare prospective payment system and the care of the frail elderly. Journal of the American Geriatrics Society, 1984, 32 (11), 843-848.
- Blumenfield, S. Discharge planning: Changes for hospital social work in a new health care climate. Quality Review Bulletin, February 1986, 12 (2), 51-54.
- Brody, S. & Magel, J. DRG: The second revolution in health care for the elderly. Journal of the American Geriatrics Society, 1984, 32 (9), 678.
- Clausen, C. Staff RN: A discharge planner for every patient. Nursing Management, November 1984, 15 (11), 58-61.
- 42 Code of Federal Regulations. Washington, D.C.: U.S. Government Printing Office.
- Coe, M., Wilkerson, A., & Patterson, P. The impact of DRGs. Beaverton, Oregon: Northwest Oregon Health Systems, May 1986.
- Coleman, S. Discharge planning from the home health agency. In P. O'Hare & M. Terry, Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.
- Committee on Government Operations. Quicker and sicker: Substandard treatment of Medicare patients. Washington, D.C.: U.S. Government Printing Office, November 30, 1989.
- Cunningham, L. Early assessment for discharge planning. Quality Review Bulletin, 1982, Special Edition, 66-71.
- Cunningham, L. Early assessment for discharge planning: Adopting a high-risk screening program. Quality Review Bulletin, December 1984, 561-565.
- Discharge planning: Condition of Participation. Discharge Planning Update. November-December 1988, 8 (6), 1, 17-18.
- Eggers, P. Prospective payment system and quality: Early results and research strategy. Health Care Financing Review, Annual Supplement, 1987, 29-37.

- 
- Fagan, J. Developing an information system for discharge planning under prospective pricing. Discharge Planning Update, 1984, 4 (3), 5-9.
- Feather, J. Summary report: National hospital discharge planning study. (Unpublished paper). June 1988.
- Feather, J. & Nichols, L. Hospital discharge planning for continuity of care: The national perspective. In E. Hartigan & D. Brown (Eds.), Discharge planning for continuity of care (revised edition). National League for Nursing, Publication #20-1977- 1985.
- Fitzig, C. Discharge planning: Nursing focus. In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.
- Frasca, C. & Christy, M. Assuring continuity of care through a hospital-based home health agency. Quality Review Bulletin, 1986, 12 (5), 167- 171.
- General Accounting Office. Information requirements for evaluating the impacts of Medicare prospective payment on post-hospital long-term-care services: Preliminary report. (GAO/PEMD-85-S). Washington, D.C.: Government Printing Office, February 1985.
- General Accounting Office. Post-hospital care: Discharge planners report increasing difficulty in placing Medicare patients. GAO/PEMD-87-5BR. Washington, D.C., January 1987.
- Gooding, J. & Jette, A. Hospital readmissions among the elderly. Journal of the American Geriatrics Society, 1985, 33 (9), 595-601.
- Gornick, M. & Hall, M. Trends in Medicare use of post-hospital care. Health Care Financing Review, 1988 Annual Supplement, 27-38.
- Graham, H. & Livesley, B. Can readmissions to a geriatric medical unit be prevented? Lancet, 1983, 1, 404-406.
- Griggs, M. The role of the nurse in the continuum of care. In C. Evashwick & L. Weiss (Eds.), Managing the continuum of care. Rockville, Maryland: Aspen Publishers, 1987.
- Guterman, S. & Dobson, A. Impact of Medicare prospective payment system for hospitals. Health Care Financing Review, 1986, 7 (3), 97-114.
- Hartigan, E. Discharge planning: Identification of high-risk groups. Nursing Management. December 1987, 18 (12), 30-32.
- Hazzard, W. The physician's role in the continuum of care. In C. Evashwick & L. Weiss (Eds.), Managing the continuum of care. Rockville, Maryland: Aspen Publishers, 1987.
- Health Care Financing Administration. Status Report on Research and Demonstrations in Health Care Financing. Fiscal Year 1988 Edition. Baltimore, Maryland: U.S. Department of Health and Human Services, March 1989.
- Institute for Health and Aging, University of California at San Francisco. Organizational and community responses to Medicare policy: Consequences for health and social services for the elderly. Summary results. (Unpublished paper). May 1987.
- Institute of Medicine (IoM). Medicare: A strategy for quality assurance. Washington, D.C.: National Academy Press, 1990.
- Joint Commission on Accreditation of Healthcare Organizations. 1990 Accreditation Manual for Hospitals. Chicago, Illinois: Joint Commission, 1989.



---

Kane, R. Standardized assessment as a means rather than an end. The Gerontologist, June 1990, 30 (3), 291-292.

Kitto, J. & Dale, B. Designing a brief discharge planning screen. Nursing Management, September 1985, 16 (9), 28-30.

Lawrance, F. Discharge planning: Social work focus, In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.

Mason, B., Bedwell, C. & Vanerzwaff, R. Why people are hospitalized. Medical Care, 1980, 18 (2), 147-163.

McCarthy, S. The process of discharge planning. In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.

McNulty, E. Discharge planning models. In P. Volland (Ed.), Discharge planning: An interdisciplinary approach to continuity of care. Owings Mills, Maryland: National Health Publishing, 1988.

The Medicare Quality Protection Act of 1986. Brief Summary of Provisions. June 24, 1986.

Morrow-Howell, N., Proctor, E. & Mui, A. Adequacy of discharge plans for elderly patients. Social Work Research and Abstracts, in press, accepted for publication 1990.

Nash, T. What's new about the new discharge planning standards? Discharge Planning Update, September-October 1988, 8 (5), 1; 11-13.

Newcomer, R., Wood, J. & Sankar, A. Medicare prospective payment: Anticipated effect on hospitals, other community agencies and families. Journal of Health Politics, Policy and Law, 1985, 10 (2), 275-282.

Nice, A. Multidisciplinary discharge screen. Journal of Nursing Quality Assurance, February 1989, 3 (2), 63-68.

Nonemaker, S. Needs assessment: Cornerstone of the discharge planning process. Unpublished paper, July 1990.

O'Hare, P. Developing discharge planning programs: Current and future models and strategies. In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.

O'Hare, P. An overview of discharge planning. In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.

Poe, C. Back to school? Putting certification for discharge planners to the test. Continuing Care, March 1990, 20-24; 35.

Proctor, E. & Morrow-Howell, N. Complications in discharge planning with Medicare patients. Health and Social Work, February 1990, 15 (1).

Providing for reconciliation pursuant to section 2 of the concurrent resolution on the budget for fiscal year 1987 (OBRA 1986). Conference report to accompany H.R. 5300. October 17, 1986. Report 99-1012. Washington, D.C.: U.S. Government Printing Office, 1986.

---

Prospective payment for Medicare in-patient hospital services. Washington, D.C.: Government Printing Office, 1983.

Rasmusen, L. A screening tool promotes early discharge planning. Nursing Management, May 1984, 16 (5), 39-43.

Rehr, H. Discharge planning: An ongoing function of quality care. Quality Review Bulletin, February 1986, 12 (2), 47-50.

Rehr, H., Berkman, B. & Rosenberg, G. Screening for high social risk: Principles and problems. Social Work, 1980, 25, 403-406.

Reichelt, P. & Newcomb, J. Organizational factors in discharge planning. Journal of Nursing Administration, October 1980, 36-42.

Robinson, B. Validation of a caregiver strain index. Journal of Gerontology, 1983, 38 (3), 344.

Role of discharge planners draws scrutiny. Hospitals, July 5, 1986, 108; 110.

Rubin, F. Discharge planning: Physician focus. In P. Volland (Ed.), Discharge planning: An interdisciplinary approach to continuity of care. Owings Mills, Maryland: National Health Publishing, 1988.

Scheuermann, L. Discharge planning in the nursing home. In P. O'Hare & M. Terry, Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.

Senate Special Committee on Aging. The crisis in home health care: Hearings before the Special Committee on Aging, United States Senate, Ninety-Ninth Congress, Second Session. Serial No. 99-975. Washington, D.C.: U.S. Government Printing Office, 1986.

Senate Special Committee on Aging. Quality of care under Medicare's Prospective Payment System: Hearings before the Special Committee on Aging, United States Senate, Ninety-Ninth Congress, First Session (Volumes I & II). Serial Nos. 99-9, 10, 11. Washington, D.C.: U.S. Government Printing Office, 1986.

Simmons, W.J. Planning for discharge with the elderly. Quality Review Bulletin, February 1986, 12 (2), 68-71.

Society for Hospital Social Work Directors of the American Hospital Association, Committee on Discharge Planning. Discharge planning: Direct patient care services. Chicago: American Hospital Association, September 1980.

Society for Hospital Social Work Directors of the American Hospital Association. The role of the social worker in discharge planning: Position statement. Chicago: American Hospital Association, June 1985.

Terry, M. Essential considerations in setting up a discharge planning program. In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.

Vladeck, B. The continuum of care: Principles and metaphors. In C. Evashwick & L. Weiss (Eds.), Managing the continuum of care. Rockville, Maryland: Aspen Publishers, Inc., 1987.

Volland, P. The changing health care environment. In P. Volland (Ed.), Discharge Planning: An interdisciplinary approach to continuity of care. Owings Mills, Maryland: National Health Publishing, 1988.

---

Volland, P. Evolution of discharge planning. In P. Volland (Ed.), Discharge planning: An interdisciplinary approach to continuity of care. Owings Mills, Maryland: National Health Publishing, 1988.

Waters, K. Discharge planning: An exploratory study of the process of discharge planning on geriatric wards. Journal of Advanced Nursing, 1987, 12, 71-83.

Webber, A. History and mission of quality assurance in the public sector. In E. Hughes (Ed.), Perspectives on Quality in American Health Care. Washington, D.C.: McGraw-Hill, Inc., 1988.

Zarle, N. Discharge planning: A multi-disciplinary approach. In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.

---

# CHAPTER 3: ISSUES IN CLINICAL ASSESSMENT FOR POSTHOSPITAL CARE DECISION-MAKING

While increasing in interest and importance, “assessment technology” is far from a new concept. Health care professionals have long used a wide variety of instruments, scales and procedures to evaluate patients as part of the process of assessing needs for post-hospital care.

A review of the literature reveals a vast number of assessment tools that have been developed to evaluate specific domains, or for use in particular levels of care or with specific populations.<sup>7</sup> Many of these instruments have been developed for research purposes and have been tested for reliability and validity. Other instruments have been developed for use in individual facilities. While useful to providers to facilitate clinical decision-making, these facility-specific instruments may lack the rigor associated with those developed for research purposes or more generalized application across care settings.

## A. CONSENSUS BUILDING ON ASSESSMENT METHODOLOGY

The diversity among the large number of assessment instruments that are available offers the clinician and/or facility a wide choice of instrumentation to use in decision-making regarding a patient’s needs for continuing care. This plethora of assessment methodology has allowed the provider to tailor the needs assessment

process to the facility’s own unique capabilities and resources. However, this also means that there is no assessment standard, which would ensure that the needs assessment is based on all appropriate and necessary elements, and that those performing and/or affected by the needs assessment have lacked a common vocabulary to categorize, communicate and plan for needs for continuing care.

## National Committee on Vital and Health Statistics

In 1979, the U.S. National Committee on Vital and Health Statistics of the Public Health Service identified a minimum data set for long-term care. The minimum data set specified that a comprehensive assessment of an individual’s status should include items such as: age; sex; race; marital status; living arrangement; vision/hearing/communication abilities; activities of daily living; range of mobility; adaptive tasks; disruptive behavior; orientation/memory impairment; and disturbance of mood (U.S. National Committee on Vital and Health Statistics). The need to incorporate a minimum data set in the assessment of nursing facility residents was recognized in OBRA ‘87. Federal requirements regarding the use of a minimum data set and resident assessment instrument

---

<sup>7</sup>Many excellent references that provide a complete overview of issues related to clinical assessment are available. For a more extensive discussion of assessment methodology, the reader is referred to: R. Kane & R. Kane,

Assessing the elderly: A practical guide to measurement, 1981; J. Gallo, W. Reichel & L. Andersen, Handbook of geriatric assessment, 1988; or other sources noted in the reference section of this chapter.

---

were effective October, 1990 (a more extensive discussion of the resident assessment initiative is found at the end of this chapter).

Recognizing the importance of patient assessment to the development of an appropriate and effective plan of care, several subsequent efforts have focused on bringing together health care providers to promote understanding of the necessary components of assessment methodology and the diversity of tools available to assess patients. Of particular note, two Federal conferences played an important role in furthering state-of-the-art assessment methodology.

#### **National Institute on Aging conference**

The National Institute on Aging hosted a landmark conference in 1982. Co-hosted with the Office of Medical Applications of Research of the National Institutes of Health, the American Medical Association and the National Center for Health Services Research, the purpose of the conference was two-fold: 1) to provide an opportunity for developers and users of assessment methodology to exchange information, and 2) to encourage critical analysis of existing instruments and stimulate research and evaluation efforts (Williams, 1983). In providing an overview of the importance of functional assessment, Williams found the following assessment domains essential to decisions regarding long-term care needs: physical functioning; mental and emotional functioning; availability of family and social

supports; environmental characteristics of the living setting; needs for specific medical or rehabilitative therapies; and the potential for productive or personally rewarding use of time (Williams, 1983).

#### **National Institutes of Health consensus development conference**

A National Institutes of Health (NIH) Consensus Development Conference on Geriatric Assessment Methods for Clinical Decision-making was held in 1987. The purpose of the conference was to bring together biomedical and behavioral scientists, clinicians, other health professionals with an interest in geriatric medicine and health services research, and representatives of the public to weigh scientific evidence and develop a consensus statement addressing several key issues related to geriatric assessment. The assessment process was defined, in part, as:

a multidisciplinary evaluation in which . . . problems . . . are uncovered, . . . resources and strengths . . . are catalogued, need for services assessed, and a coordinated care plan developed to focus interventions on the person's problems (NIH Consensus Development Conference Statement, 1987, p. 1).

The Consensus Panel found that a comprehensive geriatric assessment usually includes an evaluation of several domains: physical, mental, social, economic, functional and environmental. Using this framework, the following elements were considered of

- 
- o Physical Health - Patient history may include use of prescription and nonprescription medications; presence of malnutrition, falling, incontinence, immobility, smoking and alcohol use; immunization status; exercise habits; sexual functioning; visual or hearing impairment; information regarding personal strengths, values, perceived quality of life and expected outcomes of care.
  - o Mental Health - Evaluation of cognitive, behavioral and emotional status, including detection of dementia, delirium and depression.
  - o Social and Economic Status-Identification of present and potential caregivers, with evaluation of their competence, willingness and acceptability to the patient. Presence of cultural, ethnic and/or spiritual values. Evaluation of economic resources that may determine access and/or available options for care.
  - o Functional Status - Measure of ability to perform activities of daily living and instrumental activities of daily living. While most accurately evaluated by direct observation in the home, accurate information may be obtained by standardized questionnaire or self-report.
  - o Environmental Characteristics - Determination of the safety, physical barriers and layout of the home, in addition to access to services (e.g., shopping, pharmacy); assessed via home visit or questionnaire.

In debating the comparative merits of different assessment methodology, the Consensus Panel found that it was not possible to identify the best

instrument in each domain, due to a lack of studies that directly compare one method to another (NIH Consensus Development Conference Statement, 1987).

## **B. OVERVIEW OF ASSESSMENT DOMAINS**

In developing a framework for the needs assessment instrument, the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) drew upon the following tenets garnered through a review of the literature, as well as the clinical experience and values of individual Panel members.

### **Functional status**

The importance of an individual's functional status to a determination of continuing care needs is underscored repeatedly throughout the literature. A systematic method to assess functional status provides a task-specific framework to evaluate the patient's ability to perform activities necessary to live independently in the home (Gallo, Reichel & Andersen, 1988).

Functional status is viewed along a continuum and examines the patient's degree of independence in a variety of areas that include but are not limited to, Activities of Daily Living (ADLs), Mobility, Communication and Instrumental Activities of Daily Living (IADLs). ADLs are functions that are fundamental to independent living, and were initially measured by Katz in

---

terms of bathing, dressing, toileting, transfer from bed or chair, continence and feeding (Katz, Ford, Moskowitz, Jackson & Jaffee, 1963). As conceived by Lawton and Brody, a more complex set of activities, termed IADLs, examines the individual's ability to cope in his environment. IADL functions include adaptive tasks such as shopping, cooking, housekeeping, doing laundry, using transportation, managing money, managing medications and using the telephone (1969).

Many factors related to the patient's physical or cognitive status (e.g., blindness) vary greatly in terms of their role in shaping a patient's needs for post-hospital care. As such, the needs assessment must be capable of ascertaining the actual effect of such impairments as evidenced by the presence of functional incapacities (i.e., self-care deficits). Assessing a patient's needs for care from a functional perspective is done by translating the patient's functional capability to a measure of the amount of physical assistance and/or supervision that would be necessary to complete ADL and IADL related activities.

The Panel reviewed over 50 published functional assessment instruments, which have been used in a variety of settings for different purposes. Items and definitions common to many of the instruments were extrapolated and issues related to definition of items, scaling and the method for obtaining information were addressed. Functional assessment instruments range widely

in scope and complexity, with as few as 3 and as many as 10 levels comprising their rating scales. On the average, rating scales employ five levels (maximum, moderate, minimal, standby assistance or supervision, and independent). Several rating instruments also consider whether special equipment and/or assistive device(s) are needed. Some rating schemes provide a composite score for all of the items, while others yield a subscore for each category. Quantifiable data is needed for statistical or comparison purposes, while less discrete data that may simply describe the patient's capabilities can be used for more practical or clinical applications (S. Forer, Panel presentation, August 3, 1988).

The Index of ADL, developed by Katz et al. in 1963, is one of the best known and most carefully evaluated measures of functional status. The tool was developed to assess functional capacity in chronically ill and aging populations. The assessor must observe and rate the patient's performance in six functions (bathing, dressing, going to the toilet, transfer, continence and feeding), using a dichotomous scale. Katz and his colleagues have demonstrated in a number of studies that there is a natural progression in both the loss and recovery of ADL capabilities' (Kane & Kane, 1981). The time required to administer the Index is less than 5 minutes for trained assessors familiar with the patient.

---

\*Katz et al. based the Index of ADL upon a hierarchical framework, postulating that the recovery of independent functioning occurs initially with indepen-

dence in feeding and continence, then in transfers and toileting, and finally, in dressing and bathing.

---

The Index of ADL has been used and evaluated in a variety of settings. These include a home care program; a nursing home; a county hospital specializing in chronic and/or prolonged illness; a general hospital; an outpatient clinic of a general hospital; nonhospitalized patients with multiple sclerosis (a national longitudinal study); hospitalized patients with a hip fracture (a national longitudinal study); custodial patients (a national longitudinal study); and select practices of orthopedic surgeons (Ernst & Ernst, 1984).

A number of subsequently developed functional assessment tools have drawn upon the items and definitions originally developed by Katz. In addition, the Katz ADL rating scale has been adapted to incorporate a Likert scale system to allow the assessment of more discrete levels of functional status<sup>3</sup> (Kane & Kane, 1981).

Other notable instruments developed to assess functional status include:

- o The PULSES Profile, developed by E. Moskowitz and C. McCann in 1957, was one of the first functional assessment instruments. It was designed to assess not only physical functioning but also cognitive/behavioral status, the need for medical and/or nursing monitoring, and social factors.
- o The Barthel Index, developed by F. Mahoney and D. Barthel in 1965, assesses functional capability in terms of

feeding, grooming, transferring, toileting, bathing, ambulation and continence. This tool was later modified by Granger to include a series of four point ordinal scales, the Barthel Self-Care Ratings (Sherwood, Morris, Mor & Gutkin, 1977).

- o The Rapid Disability Rating Scale (RDRS), developed by M. Linn in 1967, combines ADL and IADL functions and rates functional status on a three point scale.
- o The Functional Independence Measure (FIM) was developed by B. Hamilton et al. (1987) as the basis for a Uniform Data System for Medical Rehabilitation. The instrument was developed in conjunction with a national task force, with the goal of improving the rehabilitation community's ability to describe and communicate about disability (B. Hamilton, Panel presentation, June 1, 1988).

### **Mental status**

The Panel addressed issues in the definition and diagnosis of several of the more common mental health problems of the elderly. Problems that may affect a patient's needs for care include:

- o Thinking disorders - Late onset schizophrenia, paranoid delusional disorders and chronic psychoses are the most common thinking disorders seen in the elderly.

---

<sup>3</sup>For example, a four point scale, with levels defined as: 0 = no assistance needed; 1 = needs an assistive device to complete; 2 = needs human assistance; 3 =

completely dependent, could be used to provide a composite sum to describe functional status.



- 
- o Affective disorders - The most common affective disorders among the elderly are major (clinical) depression and dysthymia. Anxiety disorders, which may be environmentally induced, are also common.
  - o Cognitive disorders - Delirium and dementia are cognitive disorders that increase markedly with age..

The Panel acknowledged that it is often difficult to distinguish between problems with behavior and cognition, particularly in patients with dementia. Dementia is properly characterized from a functional perspective as a group of symptoms associated with the gradual, generalized and persistent loss of cognitive function (G. Maletta, Panel presentation, August 3, 1988).

Cognitive and behavioral factors play a large role in determining needs for care. Cognitive abilities that can be diminished or lost in individuals with dementia include memory, intelligence, learning ability, calculation, problem solving, judgment, comprehension, recognition, orientation and attention. Many functional incapacities are the result of cognitive impairments. However, while cognitive impairments are known to lessen self-care abilities, the causal relationship and resulting degree of impairment are not well understood. An Office of Technology Assessment (OTA) Advisory Panel for Assessment of Disorders Causing Dementia found that some patients who do poorly on cognitive tests are nevertheless able

to function independently (U.S. Congress, OTA, 1987). The OTA report added the following caveat in discussing the use of assessment data to determine needs for care:

Because of the apparent complexity of the relationship between cognitive and self-care deficits, measures of self-care abilities may be more reliable and valid than even the best cognitive measures for public policy applications such as establishing eligibility and determining reimbursement for long-term care services. Still many persons with self-care deficits do not have cognitive impairment. Thus measures of self-care abilities are clearly not valid indicators of cognitive status. Likewise, they are inadequate for planning clinical and long-term care for persons with and without cognitive impairment. For these purposes, knowledge of the individual's cognitive status and the relationship between his or her cognitive abilities and self-care deficits is essential (U.S. Congress, OTA, 1987, p. 301).

Behavioral problems associated with dementia can include wandering and getting lost; agitation; pacing; emotional outbursts; suspiciousness and angry accusations; physical aggression; combativeness; cursing; socially unacceptable sexual behavior; chronic screaming or noisiness; repetition of meaningless words, phrases, or actions; withdrawal and apathy; hoarding; and sleep disruption. While cognitive deficits that result in impaired self-care abilities generally create a need for informal and formal long-term care services, behavioral problems are often the most burdensome aspect of dementia for caregivers. Behavioral problems not only result in needs for care but also affect the family/

---

support system's ability and willingness to continue with community-based care (U.S. Congress, OTA, 1987).<sup>4</sup>

A number of instruments have been developed to assess mental status. Instruments that focus on cognitive abilities and are derived from the clinical mental status exam include:

- o Mental Status Questionnaire (Kahn, Goldfarb, Pollack et al., 1963);
- o Mini-Mental State Examination (Folstein, Folstein & McHugh, 1975); and
- o Short Portable 'Mental Status Questionnaire (Pfeiffer, 1975).

Instruments developed to measure behavioral problems include:

- o Behavior Scale: Psychogeriatric Dependency Rating Scale (Wilkinson & Graham-White, 1980);
- o Behavioral and Mood Disturbance Scale (Greene, Smith, Gardiner et al., 1982); and
- o Relatives' Stress Scale (Greene, Smith, Gardiner et al., 1982).

## **Nursing and other care requirements**

An assessment of nursing and other care requirements incorporates social, functional and clinical factors. A review of current discharge planning practices indicated that social factors, such as pre-admission living arrangements and the presence of familial and community support services, are used in conjunction with functionally oriented factors (i.e., mental status; vision, hearing and dentition; continence; activities of daily living) in performing a preliminary assessment of nursing and other care requirements.

In addition, clinical needs for professional care that may continue after discharge must be assessed. Examples of care that may be required in a post-acute care setting include: ventilator support; tracheostomy care; oxygen therapy; enteral and/or parenteral therapy; foley catheter maintenance; ostomy care; wound care; preventive skin care and/or decubitus ulcer care; medication management and/or administration; and other special patient/family educational needs. The need for specific therapies, durable medical equipment and/or disposable supplies must also be assessed (A. McBroom, Panel presentation, August 3, 1988; Hartigen & Brown, 1985).

---

<sup>4</sup>See Losing a million minds: Confronting the tragedy of Alzheimer's disease and other dementias, from the U.S. Congress OTA (1987), for a comprehensive discussion of issues surrounding the assessment of cognitive

and behavioral status. The report includes methodological and process considerations as well as an analysis of the role and use of assessment methodology in public policy.

---

Few formal instruments to assess nursing and other care needs have been developed. Many facilities have designed their own discharge planning worksheets to identify clinical needs and services that must be met after discharge.<sup>5</sup>

A demonstration project conducted by the Burke Rehabilitation Center and funded by the Kellogg Foundation examined methods to implement a multidimensional patient assessment system in order to promote early identification of needs for post-hospital services. Three hospitals modified their patient information systems; in particular, they developed methods to capitalize on data collected via the nursing admission assessment. Nursing data bases were revised to include a broad evaluation of functional and social factors, and discharge forms (nursing discharge summaries and/or discharge planning worksheets) were developed or adapted to identify needs for post-hospital services. The types of assessment elements found on the forms had previously been sought by staff as the basis for clinical decision-making. However, the success of the demonstration was attributed to standardizing the content, process and

documentation of assessment data (Burke Rehabilitation Center, 1987).<sup>6</sup>

There remains a great deal of variability in the methods used to classify and measure nursing care needs. However, several efforts have worked towards the establishment of a common nomenclature system.

The Nursing Minimum Data Set (NMDS) has been developed to:

establish comparability of nursing data across clinical populations, settings, geographic areas and time, through identification of data categories ... or elements; and uniform definitions of these for use in nursing's clinical practice and administrative, research and educational endeavors. ... data are needed to describe the health status of various populations in reference to nursing care needs; to assess, diagnose, plan, intervene or manage, and evaluate nursing care; and to investigate the quality and outcome of nursing care, the availability and costs of nursing resources, and the use and costs of nursing services (Werley, 1988, pp. 7-8).

The NMDS items were generated and refined during a series of task force meetings in 1985. The NMDS classifies nursing care items according to Nursing Diagnosis, Nursing

---

<sup>5</sup>For example, the Panel reviewed several facility-specific forms used to assess nursing and other care requirements, such as Valley Presbyterian Hospital's (California) Discharge Planning Assessment.

<sup>6</sup>Hospitals participating in the demonstration included South Shore Hospital and Medical Center

(Florida); Middlesex Memorial Hospital (Connecticut); and St. Vincent's Medical Center (Connecticut). A user's manual is available, which contains the initial assessment and discharge planning forms, as well as definitions and instructions for their use (Burke Rehabilitation Center, 1987).

---

Intervention, Nursing Outcome and Intensity of Nursing Care. Two classification systems for Nursing Interventions have been developed,<sup>7</sup> but were judged “not discriminating enough nor exhaustive and mutually exclusive” in initial NMDS testing (Werley & Lang, 1988, p. 410).

A series of Federally funded studies<sup>8</sup> have resulted in the development of a practice and documentation framework for community health agencies, the Visiting Nurse Association (VNA) of Omaha Classification System. The first phase of the project began in 1975 with the development of the Problem Classification Scheme, a taxonomy of client problems addressed by community health nurses. The scheme is nonexhaustive, mutually exclusive and organizes a list of 40 patient problems under four domains: Environmental, Psychosocial, Physiologic and Health-Related Behaviors. A complementary Intervention Scheme was then designed, which contains nursing interventions designed to address specific problems. Categories include health teaching, guidance and counseling; treatments and procedures; case management; and surveillance (Martin, 1988).

The system has been implemented in 72 home health or public health agencies and is being used by 3734 community health nurses, according to the results of a 1989 survey (K. Martin, personal communication, May 1990). Advantages of the system include: simplified documentation through the use of standardized terminology; increased continuity of care; enhanced communication among staff, supervisors, management and external reviewers; and the creation of a data base for informed fiscal, staffing and service program decisions (VNA of Omaha, 1986).

Building upon the VNA of Omaha Classification System, Peters reviewed the domains of the Problem Classification Scheme and developed a construct that subdivides the four domains into fifteen community health parameters. The construct draws upon an assessment of the patient’s clinical status to determine and categorize needs for nursing care and other home care services. As such, the construct provides a framework for organizing and delivering services, as well as improving the documentation of the types of interventions that are performed. The content of each parameter is

---

<sup>7</sup>The seven-category classification scheme defines nursing interventions in terms of: surveillance and/or observation, supportive measures, assistive measures, treatments and/or procedures, emotional support, teaching and coordination. The alternate sixteen-category scheme for classification breaks out interventions according to: monitoring and/or surveillance, activities of daily living, comfort, airway maintenance, applications and/or treatments, medications, invasive insertions, emotional support and/or counseling, teaching, coordination and collaboration of care, protection, assisting other providers,

preventive services, providing a therapeutic environment, maintaining nutritional and fluid balance, and therapeutic activities.

\*Funding for the Omaha Classification System was supplied by the Department of Health and Human Services’ (HHS) Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing. The Health Resources and Services Administration is a component of the Public Health Service.

---

organized around the nursing process (i.e., assessment, planning, implementation and evaluation). The assessment and evaluation components focus on the patient. The planning and implementation components focus on the activities of the nurse. Thus, the construct offers a description of the types of patients receiving home care and the services that are provided (Peters, 1988).

Peters' construct organizes the patient assessment according to:

- o Environmental - Captures information on the home environment of the patient. Parameters are finances and housing, which includes safety and health.
- o Psychosocial - Captures information on motivation, patient attitude, willingness, family support, family and community resources and the availability and ability of potential resources/caregivers. Parameters include community networking, family systems, emotional response and individual growth and development.
- o Physiological - Captures most treatments as well as functional limitations and cognitive ability. Parameters include sensory function, respiratory and circulatory function neuromusculo-skeletal function, reproductive function, digestive/elimination function and structural integrity.
- o Health behaviors - Encompasses the strengths as well as the weaknesses of the patient and assesses health-seeking behaviors that have the potential of improving the quality of a patient's life. Parameters include nutrition, personal

habits and healthmanagement (D. Peters, Panel presentation, August 3, 1988).

### **Family and community supports**

Evidence supporting the crucial role of social factors in an assessment of long-term care needs continues to grow but the measurement of social support has proved difficult. The critical characteristics of this assessment domain have not yet been identified and measures have generally lacked validation. "Social network" is used to describe the web of social relationships that surround a person, while "social support" is defined as the emotional, instrumental or financial assistance that may be obtained from the social network. As networks may provide no or limited support, it is misleading to assume that support is available simply because a social network is identified (Berkman, 1983).

Several factors play a role in shaping the caregiver's decision to provide care in the home. They include:

- o quality of the relationship between patient and caregiver;
- o promises and pacts made between the patient and caregiver;
- o influence of health professionals and family members, particularly children;
- o financial necessity; and
- o attitudes and perceptions regarding nursing homes (McCann, 1988).

Caregivers provide support by performing varied functions that are necessary to assist the patient in overcoming limitations that may be primarily physical, cognitive or a combination of both. Physical care tasks include personal care, administration of medications and performance of therapeutic tasks such as Hickman catheter care or tube feedings. Additionally, a 1988 study revealed that caregivers reported the provision of psychosocial support as the most significant part of their responsibilities; 92% of caregivers talked about the importance of providing “moral support” and “motivating” the patient to participate in care (McCann).

Numerous tools have been developed to measure a patient’s social network in terms of type and frequency of social interactions and potential resources (Kane & Kane, 1981). However, the Panel found that few tools have been developed to assess the type and degree of social support that is actually available and capable of providing for continuing care needs. In current discharge planning practice, there is a tendency to use single-item indicators (e.g., “lives alone”) to assess the absence of care networks, which then target the patient for a more intensive evaluation. Formal and informal supports must be evaluated in more depth, with the needs assessment focusing on the following:

#### 0 Informal Supports

- Availability: There is a tendency to assume that the person(s) listed as a resource is available to provide care. Criteria should be applied to evalu-

ate whether the designated resource is actually available to provide care to the extent that is required.

- Motivation: A potential caregiver’s willingness and interest in caring for a patient must be assessed.
- Ability: an interested, motivated and available potential caregiver may not be able to provide more complex forms of care or be physically capable of performing the degree of care that is required.
- Capacity: necessary to also assess the other responsibilities of the potential caregiver (e.g., work and/or other family responsibilities).

#### o Formal Supports

Gaps in service: There must be mechanisms to ascertain the level and types of organized support that exist in the community. The availability of community services varies widely depending upon geographical location and the presence of State and/or local programs.

- Accessibility to and quality of community services: The service must be available, at the level and times required by the patient. Even if a particular service is available in the community, there may be a lengthy waiting period between application and actual delivery of the service. The quality of the service should also be known.
- Cost of services: Financial considerations, such as whether the patient is eligible for public programs, covered for a particular service by a third party payer or able to self-pay, must be assessed (J. Rudman, Panel presentation, August 3, 1988).

---

The Panel reviewed several tools for assessing social supports:

- o Lubben Social Network Scale -This scale examines four basic areas: marital status, relationships with relatives and friends, church membership and membership in other organizations and clubs. The ten items are scaled from zero to five, with a score of fifty indicating the most complete network of support (Lubben, 1988).
- o The Oregon Medical Professional Review Organization (OMPRO) Extension to the Northwest Oregon Health Systems (NOHS) Patient Dependency at Discharge Instrument - This instrument was developed to supplement functional and physiological criteria used by NOHS in a post-PPS study that examined patient dependency. The OMPRO extension used a four point scale to evaluate the patient's social and caregiver supports in terms of: bereavement of spouse or significant other; adequacy of caregiver, paid or unpaid; quality of informal support and quality of formal community support (OJMPRO, 1986).
- o Geriatric Functional Rating Scale - Developed by Grauer and Bimbom in 1975 to determine the need for institutional care, this comprehensive tool contains a psychosocial section. Items include the living alone factor, ability to shop, availability of supports for recreation and geographic availability of

community support services. The instrument also includes an item to assess ethnic compatibility, a useful and desirable factor not included in most instruments (Grauer & Bimbom, 1975).

- o California Department of Aging Seed Instrument (1987) - This instrument consists of a number of screens and is used for case management purposes in California.<sup>9</sup> One screen, "Psychosocial Assessment of Formal Services", looks at the adequacy of available services in terms of the number of available services and their rate of utilization, assessing intensity of use in terms of units per month. The "Linkages" Screen examines formal and informal support, in terms of the level, strength and effectiveness of the support.

### **Assuring patient/family self-determination**

The Panel reviewed a five step process used to individualize health care decisions (Jahnigen, 1987), which was accepted as a framework to incorporate the patient's values and goals for care into the discharge planning process. The process includes assessment of the patient's value system as well as objectives and expectations for care. This allows the physician to reconcile the patient's preferences with medical information and the proposed course of therapy, thereby lessening the possibility that inappropriate or unwanted care is

---

<sup>9</sup>The Seed Instrument was developed by the California Department of Aging to provide a common assessment instrument for use by public and private case-management programs in the State. The use of a common

instrument was intended to avoid redundant interviewing of frail clients as they move from hospital to case management programs.

---

provided (D. Jahnigen, Panel presentation, August 3, 1988).

Barriers to self-determination were discussed. The limited amount of time available for discharge planning and the lack of a common vocabulary to discuss care needs may restrict the patient/family's ability to understand care requirements or share useful information.

Opportunities must be given for the patient and family to express their desires and preferences, and provisions must be made for all members of the health care team to share this information in an appropriate manner (E. Williams, Panel presentation, August 3, 1988).

A beneficiary perspective highlighted the importance of:

- o Explaining the needs assessment and discharge planning process to the patient and family;
- o Allowing the patient to serve as the primary source of information regarding needs, particularly emotional, social and housing needs;
- o Having a written record of the patient's expectations regarding care and his ability to return home, with expectations incorporated into the plan of care;
- o Informing patients of their options and honoring their wishes regarding treatment and placement to the extent possible;
- o Involving the patient as an active participant in the following aspects of the discharge planning process:

determination of the services needed, assessment of the need and/or the desire for relocation, determination of whether the caregiver will participate in the planning process, selection of providers and arrangement of service provisions; and

- o Developing a discharge plan based upon the needs of the patient, not by the services that are readily available (V. Hurst, Panel presentation, August 3, 1988).

Patient and family satisfaction with discharge plans have been associated with their involvement in the planning and decision-making process (Arenth & Mamon, 1985; Dunkle, Coulton, MacKintosh & Goode, 1983). In addition, a recent study found that the adequacy of discharge plans was impaired by complications in working with patients/families and lack of family availability (Morrow-Howell, Proctor & Mui, in press). This finding suggests that continuing care needs may not be appropriately met when patients and families are not optimally involved in the discharge planning process, underscoring the importance of facilitating patient and family participation in the needs assessment.

Several factors are associated with greater patient participation in decision-making, including minimal mental impairment, the perception of available alternatives for consideration, family support for involvement and knowledge of long-term care resources (Coulton, Dunkle, Goode & Mackintosh, 1982).



---

### **Factors that may be predictive of the need for continuing care**

The utility of the needs assessment instrument as a basis for decision-making regarding post-hospital care needs is enhanced by developing an understanding of factors that have been shown to be predictive of needs for continuing care. The Panel examined a number of factors associated with the use of facility and community-based care.

A number of studies (Wachtel, Fulton & Goldfarb, 1987; Glass, Mulvihill, Smith et al., 1977) have identified factors associated with an increased risk of institutionalization. Characteristics associated with nursing home placement include inability to perform ADLs, incontinence, mental impairment, age greater than 85 and the lack of a willing and capable caregiver.

Converse relationships of similar factors have been demonstrated as increasing a patient's likelihood of being discharged home from a nursing facility. Dimensions of health status, such as the level of cognitive and physical functioning, have consistently been reported as key predictors of returning home (Kane, Bell, Riegler, Wilson & Keeler, 1983; Liu & Manton, 1983; Retsinas & Garrity, 1986). Additionally, a study of elderly persons residing in residential care homes (RCH) revealed that while sociocultural characteristics play a role, functional and cognitive status are of primary importance in predicting whether the resident will return home

from the RCH (Bear, 1990). These studies (Kane et al., 1983; Liu & Manton, 1983; Retsinas & Garrity, 1986; Bear, 1990) also reveal that the effect of social supports on whether the individual will receive facility-based care is confined primarily to the point of entry. Social networks delay the use of long-term care facilities until care at home is no longer manageable. As such, the potential for discharge from facility-based care is more dependent on factors related to health status and needs for therapeutic or supportive care rather than the presence of social support.

An algorithm for determining needs for long-term care has been developed by Williams (1982). The model uses a hierarchical, decision-tree approach, based upon an individual's mental and functional status as well as needs for therapeutic care. In addition, several scales have been developed to predict a patient's need for facility-based care. A weighted functional scale, consisting of items assessing vision, hearing and mental status; functional status (ADLs and ability to ambulate); social status; and the presence of factors such as incontinence, paralysis, amputation, decubitus ulcers and contractures, has been developed for use with the hip fracture population (Keene & Andersen, 1982). The Functional Rating Scale for the Symptoms of Dementia is a functionally based questionnaire used to evaluate the dementia patient's need for nursing home placement (Hutton, Dippel, Loewenson et al., 1985).

The Panel found that certain functional assessment items are more predictive of the need

---

for continuing care than others. Research has demonstrated that functional incapacities related to bowel and bladder management as well as some of the ADL activities, such as eating and dressing, are most predictive of the need for supportive care. In some cases, factors related to cognition, communication and psychosocial areas tend to be weaker predictors of the amount of care that is required. However, a panelist felt these conclusions may have been biased by the quality of available scales or inherent difficulties in measuring “soft” assessment domains (S. Forer, Panel presentation, August 3, 1988).

As patients are discharged from hospitals sooner and with more complex needs for care, there has been an increase in admissions to nursing facilities that provide short-term post-hospital skilled care. In clinical practice, certain diagnoses often trigger initiation of a needs assessment. For example, patients admitted to hospitals with some orthopedic diagnoses are assessed for the presence of risk factors that may be predictive of the need for continuing care. They include: living alone, living in a two-story home, incontinence, confusion, night wandering and absence of family support (M. Knapp, Panel presentation, August 3, 1988).

The Panel attempted to identify factors that are predictive of a patient’s need for home health care services, but found there is tremendous diversity among patient status and the types of

care needs that are met by home health services. The nature and scope of home care services have expanded to address more complex and high-tech needs that must be met over a longer period of time. The goals of the patient and the availability of resources, including family support, seem to be the most influential factors in determining whether the patient’s needs can be addressed through home care (D. Peters, Panel presentation, August 3, 1988).

Kane and Kane support this conclusion, stating that “home care is possible for anyone if the resources are available” (1981, p. 262). The Kanes add that socioeconomic factors (i.e., income, housing and the availability of informal and/or formal care) seem to be the key determinants of whether institutional placement will be necessary.

### **C. MULTIDIMENSIONAL ASSESSMENT INSTRUMENTS**

A number of comprehensive instruments have been developed to assess patients’ needs for continuing care. They vary greatly in terms of their content; scope; time and resource requirements; potential for application across care settings; and reliability and validity.<sup>10</sup>

---

<sup>10</sup>Kane and Kane (1981) found that information on reliability and validity is not readily available for most multidimensional instruments. Mangen and Peterson evaluated a number of commonly used instruments that contain

elements to assess functional, medical, psychological and social needs and were suitable for use in a variety of care settings; none had acceptable levels of reliability and validity (1984).

---

## **Prototypical multidimensional instruments**

The following are noteworthy examples of systematic efforts to develop multidimensional assessment instruments:

- o The Older Americans Resources and Services (OARS) instrument was developed by researchers at Duke University in 1975. The instrument assesses health status (physical and mental), functional status (in terms of ADLs and IADLs) and social and economic resources.

The OARS was subsequently revised and shortened to produce the Multidimensional Functional-Assessment Questionnaire (MFAQ). The MFAQ consists of 105 questions and requires approximately one hour to administer (Kane & Kane, 1981).

- o Efforts funded by the Department of Health, Education and Welfare to develop a systematic approach to patient care management (PCM) resulted in the development of several instruments known as the Patient Appraisal and Care Evaluation (PACE) system. Researchers<sup>11</sup> developed the Patient Classification Form (PCF)<sup>12</sup> in the early 1970s. The tool was intended for use in clinical management, administration of facility and community-based long-term care programs, policymaking,

epidemiologic research and education. The goal of the PCF was to provide uniform terminology and consistency so that “health care personnel could systematically identify needs of patients, plan appropriate care to meet those needs and evaluate the outcomes of that care” (Patient Care Management Manual, 1980, p. 1).

A pilot test of the PCF was conducted in 19 States and the tool was revised to incorporate suggestions from over 500 individuals, including providers, State and Federal personnel and associations representing providers and consumers. The revised version became known as the PACE II and was an 18 page tool with an emphasis on the assessment of medical and nursing care needs. It has been criticized for not containing enough psychosocial data to guide decisions regarding community-based care. As with the PCF, no scoring algorithm was developed. Multidisciplinary teams were intended to assess needs, and establish goals and set priorities for care in conjunction with the patient and/or family (Kane & Kane, 1981).

- o The Geriatric Functional Rating Scale was developed by Grauer and Birnbom in 1975 to determine a patient’s need for institutional care. The instrument rates the patient’s physical and mental status, with impairments resulting in a negative score. Factors related to functional

---

<sup>11</sup>The original work was performed by a consortium of four universities: Case Western Reserve University Medical School, Harvard University, Johns Hopkins University School of Hygiene and Public Health, and

Syracuse University Research Corporation (Kane & Kane, 1981).

<sup>12</sup>The PCF was also known as the PACE I.

---

capabilities, the presence of social support, an adequate living environment and finances are rated and added to obtain a positive score. The final score is obtained by subtracting the negative from the positive score. While the scale has been criticized for its seemingly arbitrary scoring system, it has been shown to have some predictive validity (Kane & Kane, 1981).

### **Use of multidimensional instruments in demonstration projects**

Comprehensive assessment instruments have also been used in a number of demonstration projects undertaken to determine whether comprehensive multidisciplinary assessments could improve the appropriateness of the continuing care plan as well as lower the per capita cost of care. In particular, results from demonstration projects, such as the National Long Term Care Channeling Demonstration Project, TRIAGE and ACCESS, have had a significant impact on shaping the delivery of community-based health care services (Williams, 1983). The demonstrations provided a range of health and health-related social services (i.e., homemaker, home health, chore, home-delivered

meals, adult day care and transportation services) for specified groups of clients.<sup>13</sup>

### **State and local initiatives**

Such Federally sponsored demonstration projects inspired a number of States to undertake initiatives to reorganize or restructure benefits offered through Federal programs. These efforts have used assessment methodologies to control institutional access and/or reorganize access to community services, with numerous instruments developed for use at the State level to determine a patient's needs for long-term care services. Some instruments are used to determine the appropriateness of nursing home placement (i.e., to determine eligibility for facility-based care under the Medicaid program).<sup>14</sup> Other instruments are used to assess the need for community-based services, such as those funded through the Medicaid 2176 home and community-based service waiver program.<sup>15</sup>

Instruments in use at the State and local level vary in terms of their content and scope, with many of the instruments constructed to assess an individual's needs in terms of the services that are provided through State or local programs. Though

---

<sup>13</sup>According to Capitman (1988), many studies experienced difficulty in targeting chronically ill and functionally disabled clients for whom the provision of case management and expanded services proved cost-effective. However, exceptions appeared to be those programs that: 1) used preadmission screening of Medicaid patients seeking entry to a nursing home as the intake/eligibility process for case management and expanded services, or 2) combined State Medicaid nursing home admission criteria for targeting case management with hospital based transitional care programs or consolidated delivery systems.

<sup>14</sup>A 1981 survey found that 28 States had mandatory pre-admission screening programs for Medicaid patients prior to nursing home admission (Knowlton, Clauser & Fatula, 1982).

<sup>15</sup>Of the 95 Medicaid 2176 waiver programs approved as of April 30, 1985, 66 programs offered some type of case management service (Shaughnessy & Price, 1987).

---

many States have taken steps to decrease fragmentation and improve the coordination of services, there may be a number of instruments in use within a particular geographical region to assess an individual's needs for continuing care (i.e., eligibility for programs that support long-term care services). Providers of health care services and discharge planners in particular are faced with the task of maintaining knowledge of the variety of methods that are used to establish eligibility for continuing care services in their area.

In addition, a large number of comprehensive instruments have been developed for clinical use at the provider level to facilitate discharge planning and promote continuity of care.<sup>16</sup>

#### D. ISSUES IN INSTRUMENT DESIGN AND EVALUATION

##### **Reliability and validity**

The Panel reviewed a number of issues associated with the reliability and validity of the UNAI.<sup>17</sup> A valid and reliable instrument that has been designed for use with a specific population may prove unacceptable for general use. For this reason, previously developed "needs assessment"

instruments with acceptable levels of reliability and validity would not necessarily be appropriate for widescale use as intended by OBRA '86. The characteristics of the original study population may bias the validity of an instrument. The reliability of the instrument may also be affected by the characteristics of the user/assessor. In addition, some instruments designed for research purposes may be impractical for broader application.

According to Kane and Kane (1981), the purpose of the assessment determines what level of reliability and validity is appropriate (i.e., the extent and type of errors that are acceptable). Assessment instruments that are satisfactory for research purposes may be unacceptable for clinical use, where errors may have serious implications for an individual's care, safety and quality of life. For this reason, many experts advocate the use of assessment technology for initial screening only, to be followed by a less structured clinical evaluation (U.S. Congress, OTA, 1987). This concern may be particularly relevant should the UNAI be used as the sole mechanism to determine an individual's eligibility for post-hospital services. In this vein, the Panel expressed apprehension about the development of an eligibility determination system that precluded additional input necessary to develop an

---

<sup>16</sup>Many excellent instruments that provide a comprehensive assessment of a patient's posthospital care needs are currently in use, but a more complete discussion of specific instruments is beyond the scope of this report. However, the Panel wishes to express its appreciation to all those who forwarded such instruments to staff and to

acknowledge the significant contribution of the "state-of-the-art" to the development of the UNAI.

<sup>17</sup>Reliability refers to the degree of consistency or accuracy with which an instrument measures an attribute. Validity refers to the degree to which an instrument measures what it is supposed to be measuring.

---

appropriate plan for continuing care, such as clinical judgment and client values and goals (see Chapter 7).

Conversely, the lack of a structured assessment process may result in decisions that are based upon intuitive judgments made using incomplete information or informal observations. Many experts believe that standardized assessment technology could improve the accuracy of clinical judgments and identification of care needs as well as facilitate communication among caregivers (U.S. Congress, OTA, 1987).

### **Administrative feasibility**

In addition, the achievement of acceptable levels of reliability and validity is not the only concern when designing an instrument for use in a regulatory context. Issues associated with administrative feasibility may require the acceptance of lower levels of reliability and validity to enable a uniform system of assessment to be implemented (M.J. Namerow, Panel presentation, September 25, 1988). The Panel recognized that a thorough evaluation to establish the reliability, validity and administrative feasibility of using the UNAI would be required

(see Chapter 5 for recommendations for testing) and that further refinement of the UNAI may be indicated to obtain an appropriate balance between these factors.

## **E. HEALTH CARE FINANCING ADMINISTRATION INITIATIVES IN THE DEVELOPMENT OF STANDARDIZED ASSESSMENT METHODOLOGIES**

There has been an increase in the use of clinical assessment methodology in regulatory systems over the past several years. Previous discussion focused on State use of assessment instruments for case management and/or eligibility determination for Medicaid-covered post-hospital services. A number of States have also begun to use assessment technology to determine Medicaid reimbursement rates for nursing home care.<sup>18</sup> Case-mix payment systems systematically link the level of reimbursement to patient intensity or the level of resources necessary to provide care. A facility's case-mix is determined through indirect or direct measures. Direct measures rely upon a clinical assessment

---

<sup>18</sup>The use of resident-centered information to determine nursing facility payment rates dates back to the late 1970s and early 1980s. As of mid-1986, seven states (Illinois, Maryland, Minnesota, Montana, New York, Ohio and West Virginia) factored case-mix directly into their Medicaid payment formulas for nursing home care (Grimaldi & Jazwiecki, 1987). In the past few years, other State Medicaid agencies, including Texas, North Dakota and Massachusetts, have implemented case-mix systems

(The Circle, 1990). Other States, such as Pennsylvania, Wisconsin and Nebraska, are studying or developing case-mix methodologies (B. Cornelius, personal communication, June 1990).

Grimaldi and Jazwiecki (1987) predict continued growth of this phenomenon and feel that a case-mix reimbursement system may eventually be adopted by the Medicare program.

---

that typically classifies patients according to their functional abilities, medical and nursing care needs, and services received (Grimaldi & Jazwiecki, 1987).

In addition, there has been an increase in the use of assessment methodology for regulatory quality assurance purposes. For example, New York has developed an innovative assessment system that combines case-mix (RUG-II) with quality assurance (the New York Quality Assurance System, or NYQAS).<sup>19</sup> Assessment data compiled via the Patient Review Instrument (PRI) is analyzed to determine both reimbursement levels and the presence of possible quality of care problems (patient outcomes defined as Sentinel Health Events), which trigger a more in-depth review of care by State surveyors (D. Schneider, Panel presentation, June 2, 1988; Schneider, Fries, Foley, Desmond & Gormley, 1988).

At the Federal level, there is also increased attention directed towards the use of assessment technology for quality assurance purposes. In particular, two ongoing HCFA assessment initiatives share the UNAI's functionally based approach to assessing needs for care that is provided in post-hospital settings.

### **Resident assessment and the Minimum Data Set**

Early Federal requirements for nursing homes centered around physical safety and the adequacy of treatment and services. The goal of nursing home care was viewed as an improvement in, or maintenance of the highest possible level of, the patient's functional capabilities; however, methods to measure quality care and patient outcomes proved difficult to define through regulation. A new survey process that used state-of-the-art observation techniques to assess patient care and health status was implemented in the mid-1980s, but Federal efforts to refine and upgrade requirements for nursing homes reached a stalemate during the early 1980s (Morford, 1988).

Public and Congressional concerns regarding HCFA's proposed regulatory changes for nursing homes prompted HCFA to contract with the Institute of Medicine (IoM) in 1983 to perform a study that "would serve as the basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible" (IoM, 1986). The IoM's Committee on Nursing Home Regulation performed an indepth study of many

---

<sup>19</sup>The Veterans Administration is also using the RUG-II system nationwide for resource utilization. The RUG-II and NYQAS systems were developed by researchers at Rensselaer Polytechnic Institute and the New York

State Department of Health under HCFA grants. The NYQAS system was implemented Fall 1988 (Schneider, Fries, Foley, Desmond & Gormley, 1988).

---

of the problems associated with quality of care and quality of life in nursing homes. The Committee issued a 1986 report, Improving the Quality of Care in Nursing Homes, which recommended many changes in the regulatory policies and procedures used to assure the quality of care provided to nursing home residents (IoM, 1986). This landmark report went on to serve as the basis for many of OBRA '87's nursing home reform provisions.

The need for a uniform system of resident assessment was a key component of the IoM's recommendations. The IoM Committee noted that "providing high quality care requires careful assessment of each resident's functional, medical, mental and psychosocial status," which is needed to develop individualized plans of care (IoM, 1986, p. 74). The IoM Committee also believed that a uniform system for resident assessment was essential to the development of outcome-oriented measures of quality and an enhanced patient-focused survey process.

In October 1987, HCFA published a Notice of Proposed Rule-Making (NPRM) regarding new requirements for long term care facilities. Concomitantly, HCFA began a major initiative to develop a resident assessment system. These efforts were superseded and reshaped by the passage of OBRA '87, the nursing home reform act.

In OBRA '87, Congress supported the importance of resident assessment by requiring the Secretary to develop a resident assessment process for use by all nursing facilities

participating in the Medicare and Medicaid programs. Section 1819(b)(3) requires each nursing facility to "conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity," which is based on a uniform minimum data set specified by the Secretary (Compilation of the Social Security Laws). The assessment is to be performed on admission and yearly thereafter, as well as "on significant change" in a resident's status. While the Secretary was charged with specifying a uniform minimum data set and designating one or more resident assessment instruments, the States were allowed latitude in developing alternative assessment instruments, provided that they contained the "minimum data set" and met criteria specified by the Secretary.

In October 1988, a contract to develop and evaluate a uniform resident assessment system was awarded by HCFA to the Research Triangle Institute and its subcontractors, Hebrew Rehabilitation Center for Aged, Brown University and the University of Michigan. Several inter-related components of the resident assessment system have been developed. The Minimum Data Set (MDS) consists of core items and definitions needed to perform a comprehensive assessment. It also contains "triggers", which are one or more items used in combination to identify residents for whom specific Resident Assessment Protocols (RAPs) will be completed. The purpose of the RAPs is to provide a structured framework for a more detailed assessment of a potential problem in order to gather clinically relevant



---

information about an individual that contributes to **care** planning (HCFA unpublished paper, 1990).

### **MDS development and evaluation process**

In developing the MDS, a number of standardized assessment instruments were reviewed and compared to determine critical assessment elements. The MDS evolved through an extensive period of item analysis and revision, conducted with the assistance of advisory groups that included consumers, advocates, providers, regulators, researchers and experts in measurement. Evaluation of the MDS began with a small scale trial conducted in May and June of 1989 (Morris, Hawes, Phillips, Mor, Fries, Katz, Murphy & Drugovich, 1990). Additional field testing, including validation of the RAPs, concluded July 1990. The Secretary designated the Resident Assessment Instrument (RAI) system, which included the MDS and RAPs, in September 1990.

Nursing facilities were required to conduct a comprehensive assessment of newly admitted residents as of October 1, 1990, and to begin using the State-specified instrument after

notification by the State. Regulations specify that each assessment must be “conducted or coordinated by a registered nurse, who signs and certifies the completion of the assessment” (Federal Register, February 2, 1989, p. 5364).

HCFA intends to incorporate the use of the resident assessment system into the long-term care survey and certification process. A State agency surveyor will review data from the assessments of a stratified sample of residents in the facility to assess the appropriateness of the resident’s individualized plan of care and the actual care that is provided. Additionally, individual resident and facility profiles of data compiled via the MDS may be used to tailor surveys in the future, allowing for targeted reviews of suspected problem areas or adjustment of the survey team composition (e.g., using a pharmacist surveyor if problems in medication administration or overuse of chemical restraints are suspected). A report to the Congress evaluating the resident assessment process is due January 1, 1993 (HCFA unpublished paper, 1990).<sup>20</sup>

---

<sup>20</sup>OBRA ‘87 granted an additional impetus for the use of resident-centered data by eliminating the distinction between Skilled Nursing (SNF) and Intermediate (ICF) care and charging the Secretary to provide States with assistance in developing Medicaid case-mix payment systems for all nursing facilities.

A four year HCFA demonstration that began in 1989, the Multistate Nursing Home Case Mix and Quality

Project (NHCMQ), builds on the MDS to develop, implement and evaluate a resident-centered system for Medicare and Medicaid case-mix reimbursement and quality monitoring. An expanded version of the MDS is being used to collect data in the four demonstration states (Kansas, Maine, Mississippi and South Dakota), beginning Summer 1990 (The Circle, 1990).

---

### **Home Health Functional Assessment Instrument**

OBRA '87 also directed a change in the method used to certify home health agencies for participation in the Medicare program. In order to receive Medicare reimbursement, home health agencies must meet Federal health and safety standards known as conditions of participation. Previously, the home health survey process consisted of on-site review at the agency itself to determine compliance with standards that focused primarily on structure and process. Subject to review were the agency's personnel records, policy and procedure manuals, contracts for arranged services, patients' plans of treatment, clinical records and other relevant materials.

OBRA '87 charged the Secretary with developing a functionally based assessment instrument to be used in the home health survey process. The instrument will be used to assess "the extent to which the quality and scope of items and services furnished by the agency attained and maintained the highest practicable functional capacity" of the patient receiving home health care, as reflected in the individual's written plan of care and clinical records (Compilation of the Social Security Laws, section 1891(c)(2)).

### **Functional Assessment Instrument development and evaluation**

The Home Health Functional Assessment Instrument was developed under contract with

Abt Associates, Inc., who relied heavily upon feedback from home health care experts and associations representing providers and beneficiaries during the instrument development process. The instrument, which includes indicators of medical, nursing and rehabilitative care as required by law, underwent two field testing trials, which were completed December 1989.

As required by OBRA '87, the home health survey process has been revised to require the State agency surveyor to make home visits to a case-mix stratified sample of individuals being furnished items or services by the home health agency. State agency surveyors will begin using the functional assessment instrument during the survey of home health agencies as soon as the form and other materials needed to implement this requirement have completed the administrative approval process. The Secretary will evaluate the assessment process in a report due to the Congress by January 1, 1992.

### **Relationship to the Uniform Needs Assessment initiative**

**Throughout** the course of the Panel's deliberations, questions were received regarding the relationship of these projects to the uniform needs assessment initiative. Essentially, all three initiatives require the use of functionally based measures to assess patients from a post-acute care perspective. However, the initiatives differ in the purpose of the assessment:

- 
- o **uniform needs assessment** - to determine needs for post-discharge/continuing care from any point/setting in the continuum of care. This assessment anticipates which service(s)/type(s) of care are needed to assist the patient/family in meeting functional limitations and nursing and other care requirements;
  - o **nursing facility resident assessment** - for use by long term care facility staff to identify needs for care within the nursing facility. The instrument may also be used by State agency surveyors to evaluate the care that is provided by the nursing facility. Resident assessment data serves as the basis for the development of the nursing facility's plan of care; and
  - o **home health functional assessment instrument** - for use by the State agency surveyor to evaluate the care that is provided by a home health agency. Currently, there is no requirement for use by the provider of home health services.

OBRA '87 mandated the use of both the nursing facility resident assessment instrument and home health functional assessment instrument in the Medicare program. Also included were statutory directives regarding timetables for implementation and evaluation. OBRA '86 required the development of the uniform needs assessment instrument but did not include a requirement for its implementation. All three initiatives have relevance for Medicare's quality assurance program. While the instruments are intended for use in different care settings, they share a functionally oriented framework and an end goal of improving the quality of care provided to beneficiaries.

The nursing facility resident assessment and home health functional assessment instrument initiatives shared many of the conceptual and methodological issues addressed by the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s). The instruments must provide assessment data that is accurate, standardized and reproducible by different raters in different sites. Those responsible for the development of the instruments struggled to determine which items were critical, needing to resolve the conflict between wanting to develop a comprehensive assessment and the practical advantages associated with streamlining the assessment. The initiatives are also capable of generating data bases that could provide more consistent, useful and retrievable information regarding patient status and the care that is rendered by Medicare-participating providers than is currently available.

### **Coordination of related assessment instruments**

The Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) shared the public's general consensus regarding the need to approach the development of the above instruments utilizing a common framework and consistent terminology. (see Appendix D for a summary of public comment). This is particularly desirable for providers responsible for performing, or affected by, more than one of the assessment methodologies. In addition, it would also be

---

advantageous in terms of providing a cohesive approach to quality assurance efforts and the development of assessment-derived data bases.

While the Secretary is ultimately responsible for each of the initiatives and charged with reporting to the Congress, responsibility for overseeing the development of each of the instruments has been delegated to the Office of Survey and Certification, part of HCFA's Health Standards and Quality Bureau. During the process of developing the instruments, there was ongoing communication between HCFA staff members responsible for the projects as well as sharing of draft documents.

However, three issues impeded HCFA's ability to coordinate the development of the assessment methodologies. First, each of the instruments has a different purpose and therefore requires a different clinical approach and level of detail. Because of these variations in purpose, it is not possible for there to be complete agreement among the instruments, in terms of the types of items or scope of the assessment. Second, each of the initiatives stemmed from separate and sometimes disparate Congressional directives. The third issue is operational in nature and concerns administrative details associated with the instrument development process. Two of the instruments were developed under contract, with the assistance of other technical experts and representatives of provider and consumer groups. The UNAI was developed by a Secretariaily-appointed advisory panel, whose meetings were open to the public. The nature and scope of these

projects as well as the number of individuals involved in the instrument development processes precluded further coordination efforts within the timeframes specified by the Congress.

There is potential, however, for continued refinement of the assessment methodologies to promote the greatest possible degree of coordination that is warranted, given the variations in purpose. Both the nursing facility resident assessment and home health functional assessment initiatives call for an evaluation and allow for ongoing revision. Additionally, the uniform needs assessment instrument has yet to be field tested; refinement of the UNAI will probably occur after a period of field testing. Certainly, it would appear that the use of standardized assessment methodology for regulatory purposes is in its infancy and that there is much potential for evolution towards a more cohesive approach at the Federal level.

### **Summary**

Numerous patient assessment tools have been developed for use in particular settings or with specific patient populations. Many instruments have been developed to assess particular domains only, although a number of tools provide a comprehensive assessment. In the past, most assessment instruments were developed for clinical and/or research purposes. Generally, assessment instruments have been used in a regulatory context only at the State and/or local level for purposes associated with evaluating a

---

patient's eligibility for services or determining reimbursement levels, as in the case of those States that use case-mix systems for long-term care services.

As reforms are implemented to assure and improve the quality of care provided to beneficiaries, it can be seen that the Medicare program has entered an "age of assessment." Themes common to recent initiatives indicate Congressional recognition of the importance of developing standardized methodology to assess the needs of beneficiaries as well as to evaluate a provider's ability to meet patient needs. Requirements for providers to conduct a standardized assessment process, as well as for surveyors to use assessment data in the survey process, have the potential to do much to improve both the care provided to beneficiaries and the government's ability to perform **outcome-oriented**, clinically based quality assurance.

The following chapter discusses the development of one such standardized assessment methodology, the uniform needs assessment instrument (UNAI).

---

## References

- Arenth, L. & Mamon, J. Determining patient needs after discharge. Nursing Management, September 1985, 16 (9), 20-24.
- Bear, M. Social networks and health: Impact on returning home after entry into residential care homes. The Gerontologist, February 1990, 30 (1), 30-34
- Berkman, L. The assessment of social networks and social support in the elderly. NIA Conference on Assessment. Reprinted from the Journal of the American Geriatrics Society, November and December 1983, 31 (11,12), 743-749.
- Burke Rehabilitation Center. Patient assessment for continuing care (executive summary): The Westchester Patient Assessment Program. Battle Creek, Michigan: W.K. Kellogg Foundation, September 1987.
- Burke Rehabilitation Center. Patient assessment for continuing care (user's manual): The Westchester Patient Assessment Program. Battle Creek, Michigan: W.K. Kellogg Foundation, 1987.
- Capitman, J. Case management for long-term and acute medical care. Health Care Financing Review, 1988 Annual Supplement, 53-55.
- The Circle. Multistate Nursing Home Case Mix and Quality Demonstration: Training: Manual. Developed under HCFA Contract #500-89-0046, February 28, 1990.
- Compilation of the Social Security laws (including the Social Security Act, as amended, and related enactments through January 1, 1989). Volume 1. Committee on House Ways and Means, 101st Congress, 2nd Session. Washington: U.S. Government Printing Office.
- Coulton, C., Dunkle, R., Goode, R. & Mackintosh, J. Discharge planning as a decision making process. Health and Social Work, 1982, 7 (4), 253-261.
- Dunkle, R., Coulton, C., MacKintosh, J. & Goode, R. Factors affecting the post-hospital care planning of elderly patients in an acute care setting. Journal of Gerontological Social Work, 1982, 4 (3/4), 95-106.
- Ernst, M. & Ernst, N. Functional capacity. In D. Mangen & W. Peterson (Eds.), Research instruments in social gerontology: Health, program evaluation and demography. Minneapolis, Minnesota: University of Minnesota Press, 1984.
- Folstein, M., Folstein, S. & McHugh, P. Minimal state: A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 1975, 12, 189-198.
- Gallo, J., Reichel, W. & Andersen, L. Handbook of geriatric assessment. Aspen: Rockville, Maryland, 1988.
- Glass, R., Mulvihill, M., Smith, H. et al. The 4 score: An index for predicting a patient's non-medical hospital days. American Journal of Public Health, 1977, 67, 751-755.
- Grauer, H. & Birnbom, F. A geriatric functional rating scale to determine the need for institutional care. Journal of the American Geriatrics Society, 1975, 20, 472-476.
- Greene, J., Smith, R., Gardiner, M., et al. Measuring behavioral disturbance of elderly demented patients in the community and its effects on relatives: A factor analytic study. Age and Aging, 1982, 11 (2), 121-126.

---

Grimaldi, P. & Jazwiecki, T. Case-mix uavment systems for nursing home care. Chicago, Illinois: Pluribus Press, 1987.

Hamilton, B. et al. Guide for use of the Uniform Data Set for medical rehabilitation. Buffalo, New York: State University of New York, 1987.

Hartigen, E. & Brown, D. (Eds.). Discharge planning for continuity of care. New York: National League for Nursing, 1985.

Health Care Financing Administration. Development of a national computerized data system of nursing home resident assessments. Unpublished paper developed for use in the Office of Survey and Certification's resident assessment initiative, Health Standards and Quality Bureau, January 1990.

Hutton, J., Dippel, R., Loewenson, R. et al. Predictors of nursing home placement of patients with Alzheimer's disease. Texas Medicine, 1985, 81, 40-43.

Institute of Medicine. Improving the auality of care in nursing homes. National Academy Press: Washington, D.C., 1986.

Jahnigen, D. The changing doctor-patient relationship. Generations, Fall 1987, 12 (1), 54-56.

Kahn, R., Goldfarb, A., Pollack, M., et al. Brief objective measures for the determination of mental status in the aged. American Journal of Psvchiatrivy, 1963, 117, 326-328.

Kane, R., Bell, R., Riegler, S., Wilson, A. & Keeler, E. Predicting outcomes of nursing home patients. The Gerontologist, 1983, 23, 200-206.

Kane, R. & Kane, R. Assessing the elderlrv: A practical guide to measurement. D. C. Heath and Company: Lexington, Massachusetts, 198 1.

Katz, S., Ford, A., Moskowitz, R., Jackson, B. & Jaffee, M. Studies of illness in the aged. The Index of ADL: A standardized measure of biological and psychosocial function. Journal of the American Medical Association, 1963, 185, 9 14-919.

Keene, J. & Andersen, C. Hip fractures in the elderly. Journal of the American Medical Association, 1982, 248, 564-567.

Knowlton, J., Clauser, S. & Fatula, J. Nursing home pre-admission screening: A review of state programs. Health Care Financing Review, March 1982, 3.

Lawton, M. & Brody, E. Assessment of older people: Self- maintaining and instrumental activities of daily living. The Gerontologist, 1969, 9, 1 7 9 - 1 8 6 .

Linn, M. A rapid disability rating scale. Journal of the American Geriatrics Society, 1967, 15, 211-214.

Liu, K. & Manton, K. The characteristics and utilization pattern of an admission cohort of nursing home patients. The Gerontologist, 1983, 23, 92-98.

Lubben, J. Assessing social networks among elderly populations. Journal of Family and Community Health, 1988, 8.

Mahoney, F. & Barthel, D. Functional evaluation: The Barthel Index. Rehabilitation, 1965, 14, 61-65.

Mangen, D. & Peterson, W. (Eds.). Research instruments in social gerontology: Health, program evaluation and demography. Minneapolis, Minnesota: University of Minnesota Press, 1984.

---

Martin, K. Research in home care. Nursing Clinics of North America, June 1988, 23 (2), 373-385.

McCann, J. 'Long term home care for the elderly: Perceptions of nurses, physicians and primary caregivers. Quality Review Bulletin, March 1988, 14 (3), 66-74.

Morford, T. Nursing home regulation: History and expectations. Health Care Financing: Review, 1988 Annual Supplement, 129-132.

Morris, J., Hawes, C., Phillips, C., Mor, V., Fries, B., Katz, S., Murphy, K. & Drugovich, M. Development of resident assessment system and data base for nursing home residents: Report on the small scale trial of the minimum data set for resident assessment and care screening (MDS). Research Triangle Institute: Research Triangle Park, North Carolina, January 15, 1990.

Morrow-Howell, N., Proctor, E. & Mui, A. Adequacy of discharge plans for elderly patients. Social Work Research and Abstracts, in press, accepted for publication 1990.

Moskowitz, E. & McCann, C. Classification of disability in the chronically ill and aging. Journal of Chronic Disability, 1957, 5, 342-346.

National Institutes of Health Consensus Development Conference Statement. Geriatric assessment methods for clinical decision-making. October 19-21, 1987, 6 (13), 1-21.

Oregon Medical Professional Review Organization (OMPRO). A summary report on "sicker and quicker" issues in discharge planning. Summary of a workshop held May 30, 1986.

Patient care management manual: Long term care facility improvement program. U.S. Department of Health and Human Services, Health Care Financing Administration, Health Standards and Quality Bureau, 1980.

Peters, D. Quality care/quality documentation. Caring, 1988, 7 (10), 30-34.

Pfeiffer, E. (Ed.). Multidimensional functional assessment: The OARS methodology. Durham, North Carolina: Center for the Study of Aging and Human Development, Duke University, 1975.

Pfeiffer, E. A short portable mental status questionnaire for the assessment of organic brain deficits in elderly patients. Journal of the American Geriatrics Society, 1975, 23, 433-441.

Requirements for long term care facilities: Final rule with request for comments. Federal Register. February 2, 1989, 54 (21), 5316-5373.

Retsinas, J. & Garrity, P. Going home: Analysis of nursing home discharges. The Gerontologist, 1986, 26, 431-436.

Schneider, D., Fries, B., Foley, W., Desmond, M. & Gormley, W. Case mix for nursing home payment: Resource utilization groups, version II. Health Care Financing: Review, 1988 Annual Supplement, 39-52.

Shaughnessy, C. & Price, R. Financing and delivery of long-term care services for the elderly. In C. Evashwick & L. Weiss (Eds.), Managing the continuum of care. Rockville, Maryland: Aspen Publishers, Inc., 1987.

Sherwood, S., Morris, J., Mor, V. & Gutkin, C. Compendium of measures for describing and assessing long term care nonulations. Boston, Massachusetts: Hebrew Rehabilitation Center for Aged, 1977.



---

U.S. Congress, Office of Technology Assessment. Losing a million minds: Confronting the tragedy of Alzheimer's disease and other dementias. OTA-BA-323. Washington, D.C.: U.S. Government Printing Office, April 1987.

U.S. National Committee on Vital and Health Statistics, National Center for Health Statistics, Public Health Service. Long-term health care: Minimum data set. Washington, DC.: U.S. Department of Health, Education and Welfare, May 1979.

Visiting Nurse Association of Omaha. Client management information system for community health nursing agencies: An implementation manual. U.S. Department of Health and Human Services, Public Health Service (prepared under contract 240-84-o 106 from the Division of Nursing, Bureau of Health Professions, Health Resources and Services Administration), December 1986.

Wachtel, T., Fulton, J. & Goldfarb, J. Early prediction of discharge disposition after hospitalization. The Gerontologist, 1987, 27, 98-103.

Werley, H. Introduction to the Nursing Minimum Data Set and its development. In H. Werley & N. Lang (Eds.), Identification of the Nursing Minimum Data Set. New York: Springer Publishing Company, 1988.

Werley, H. & Lang, N. The consensually derived Nursing Minimum Data Set: Elements and definitions. In H. Werley & N. Lang (Eds.), Identification of the Nursing Minimum Data Set. New York: Springer Publishing Company, 1988.

Wilkinson, I. & Graham-White, J. Psychogeriatric dependency rating scales (PGDRS): A method of assessment for use by nurses. British Journal of Psychiatry, 1980, 137, 558-565.

Williams, T. Assessment of the elderly for long-term care. Journal of the American Geriatrics Society, 1982, 30, 71-73.

Williams, T. Comprehensive functional assessment: An overview. NIA Conference on Assessment. Reprinted from the Journal of the American Geriatrics Society, November and December 1983, 31 (11, 12), 637-641.

Williams, T. NIA Conference on Assessment: Introduction. NIA Conference on Assessment. Reprinted from the Journal of the American Geriatrics Society, November and December 1983, 31 (11, 12), 636.

---

## CHAPTER 4: THE UNIFORM NEEDS ASSESSMENT INSTRUMENT: CONTENT ISSUES

This chapter presents the uniform needs assessment instrument (UNAI). While the content of the instrument has been condensed into a four page form, the Panel struggled with and resolved a myriad of issues during its thirteen months of deliberation. The following chapter will address the process the Panel employed to develop the instrument and recount the principal issues and concerns that directed the content. It is intended to provide the reader with a better understanding of the Panel's recommendations regarding the structure and content of the uniform needs assessment instrument.

### A. PROCESS USED BY THE PANEL TO DEVELOP THE INSTRUMENT

The Panel took five steps to develop the uniform needs assessment instrument mandated by Congress. These steps were:

- o establish a common background and vocabulary, and agree on a method for making decisions as a group;
- o clarify the purpose and focus of the uniform needs assessment instrument;
- o establish the minimum content (assessment items) for assessment of continuing care needs;
- o sort the minimum content into assessment domains, if appropriate; and
- o define terms and establish measurement methodology.

### **Preliminary work: Establishing a common background**

Consideration of the historical development of discharge planning, identification of factors in the current health care environment influencing transitional care, and a review of assessment methodology were accomplished through presentations made by panelists and invited guests with expertise in discharge planning and assessment. (Presenters and their topics are listed in Appendix C). These presentations, along with a review of notable literature and a sample of assessment tools, provided the Panel with a foundation from which to pursue its objective.

Panel members' goals and ideas regarding the uniform needs assessment instrument varied. To ensure that all voices were heard, the Panel decided to make its decisions by consensus whenever possible. The Panel's consideration of each issue was as exhaustive as possible within the time constraints characteristic of such committee work. The Panel also set aside time for dialogue with the public, at each stage of its deliberations, and conducted its meetings in a variety of geographical locations in order to hear testimony representing regional concerns and perspectives.

### **Clarifying the purpose and focus of the Uniform Needs Assessment Instrument**

The Panel agreed that the legislative intent and focus of the Panel's charter was on establishing greater uniformity in the evaluation of post-

---

hospital needs of Medicare beneficiaries. It was also recognized that the Congressional intent was not to limit the Panel's scope of work to a hospital discharge planning assessment, but would involve development of an instrument or instruments that could have utility for extended care facilities, home health agencies and fiscal intermediaries.

Members of the Panel and experts from the field pointed out that continuity of care encompasses transitions across settings along the entire health care continuum, and should not be restricted to discharge planning from an acute care hospital. The importance of evaluating health and supportive care needs continues to be critical in considering post-home health care follow-up or discharge planning from a skilled nursing facility. The Panel generally viewed the components of continuity of care assessment as applicable regardless of the patient's location within the health care system and believed that assessment factors used to determine post-hospital needs should generalize to other levels of care.

Initially, the Panel chose to concentrate on developing a single instrument that would incorporate common data elements necessary to assess needs for continuing care across care settings. After study, the Panel concluded that the UNAI had a broad application, which precluded the need to create additional care setting specific instruments.

The Panel was also charged with evaluating the use of the UNAI to determine whether payment should be made for services provided to

Medicare beneficiaries. The Panel deliberately chose to utilize a clinical decision-making approach in designing the instrument rather than allow the process to be driven by the inclusion of Medicare eligibility criteria. This decision reflected the concern that development of a thorough and effective assessment instrument might be compromised if influenced by existing eligibility criteria for Medicare covered post-hospital services.

#### **Establishing a minimum data base for a uniform needs assessment**

The first question facing the Panel concerned which patient characteristics are most indicative of his or her continuing care requirements. Panelists held varied opinions on what defines an individual's need for post-hospital care. The Panel decided that contributions from its entire membership, with its diverse expertise and professional training, would be essential to the task of identifying the range of possible assessment components. Specifically, the Panel attempted to enumerate every characteristic that might define the type or extent of a patient's continuing care needs.

In plenary session, the Panel listed possible assessment items, beginning without concern for repetition of items, standardization of terms, or analysis or categorization of items. This exercise produced a list of over 100 possible items. Panelists next clarified the meaning of each item, translated items into terms understood by all, and deleted repeated items. (The final list included

---

105 items and appears as Exhibit 4- 1.) Panelists prioritized items for the assessment instrument from this list, through a Delphi-method exercise in an effort to reach a consensus on those items most critical to evaluating a patient's need for continuing care. Supporting rationale for many of the items that were selected is summarized below, in section C.

Using a consensus building approach, the Panel evaluated each proposed item to determine whether a patient's needs for post-hospital care could be adequately assessed without considering that particular item. The Panel was able to eliminate many items on its list of possible assessment components that were not considered essential to an evaluation of post-hospital needs.

Prior to conducting this exercise, the Panel received guidance from Robert Kane, M.D., an expert in assessment of the elderly (Panel presentation, August 3, 1988). Dr. Kane suggested that patient assessments are conducted for one of three purposes: care planning, defining prognosis, or charting progress. The purpose for which an assessment is being made should dictate the characteristics to be measured and the units of measurement to be used. The Panel repeatedly revisited its charge in terms of the purpose of the instrument while deliberating whether to include each item. Some items on the list were viewed as more appropriately contained as part of a comprehensive case management instrument, a tool to measure rehabilitative progress, or an interfacility transfer/referral form. The Panel believed that some items should already have been assessed and considered by staff as part of

routine hospital care. For example, the proposed item, "Results of X-rays and lab work," is part of the diagnostic and clinical data recorded on the patient's medical record. While generally of importance to the patient's next caregiver for care planning purposes, such a report would have little relevance to an assessment of post-hospital needs.

The Panel omitted many items because, although they might be useful for research purposes, they were not essential to the actual needs assessment. "Services used in the past six months," for example, may provide researchers with a precise quantification to classify and compare patients. The assessor, however, might find a requirement to collect information at this level of precision burdensome and unnecessary. "Services used immediately prior to admission" may be a more appropriate and efficient indicator to extrapolate needs for services upon discharge.

The Panel reaffirmed that the UNAI should maintain its focus as a tool for discharge planning practice, although it was acknowledged that the data collected via the instrument may provide significant contributions to health care research. A UNAI designed with its primary purpose as data collection would likely be longer and more difficult to use than an instrument constructed specifically to standardize and facilitate the needs assessment process. If the UNAI had the strictness and scope of a research instrument, its use would be limited. This would not only reduce the potential benefits to clinical practice but would also diminish the size and utility of any subsequent data base.

---

## EXHIBIT 4-1: INITIAL LIST OF POSSIBLE ASSESSMENT ITEMS

During their August 3-4, 1988, meeting, the Advisory Panel participated in an exercise to identify components for possible inclusion in a uniform needs assessment instrument. The initial listing of assessment items included:

1. home environment
2. feeding
3. patient expectations
4. patient understanding of plan or treatment
5. known health problems and diseases (active/inactive)
6. ability to attend/concentrate
7. patient/family long- and short-term goals
8. bowel/bladder function
9. pets and possessions
10. medications (prescription and over the counter)
11. medical/nursing care needs at discharge
12. ability to manage medication administration
13. diagnosis/prognosis
14. services used in last six months (including in-patient)
15. primary support to patient
16. community services available
17. standard demographics
18. ability to dress (upper and lower)
19. patient needs
20. assurance of access to recommended services
21. ability to communicate
22. level of caregiver burden
23. financial status
24. patient education needs
25. family expectations
26. ability to learn
27. functional strengths and deficits
28. indoor mobility (pre-admission and current)
29. date last physical exam and summary of findings
30. insurance/coverage
31. motivation
32. abstract thinking
33. ability to transfer
34. ability of caregivers (physical and psychosocial)
35. individual responsible for follow-up care
36. living will
37. durable power of attorney
38. level of patient cooperation
39. patient credibility
40. rehabilitation potential
41. special nursing procedures
42. patient's value system/quality of life
43. skin integrity
44. consideration of available options
45. professional expectations for change/improvement
46. physician's orders
47. needs of caregiver system/environment
48. meal preparation
49. caregiver willingness
50. ambulation
51. monitoring the adequacy of the discharge plan
52. functional/adaptive aids (i.e., dentures, walker, wheelchair)
53. insight
54. level of consciousness
55. wandering
56. high tech needs
57. ability to do housekeeping chores
58. diet
59. premorbid functional level
60. orientation (person, place and time)
61. memory
62. judgment
63. presence of hallucinations
64. patient memberships (groups/organizations/networks)
65. ability of formal health care provider to give necessary level of care

---

## EXHIBIT 4-1 continued

- |   |   |
|---|---|
| 66. language comprehension                                  | 86. pain  |
| 67. language expression                                     | 87. major procedures during admission                                   |
| 68. anxiety   | 88. activity tolerance  |
| 69. mental retardation                                      | 89. gaps in service   |
| 70. sensory impairment                                      | 90. sleeping habits   |
| 71. ability to bathe  | 91. person patient lives with   |
| 72. patient's affect  | 92. problem solving abilities   |
| 73. residential/environmental barriers                      | 93. immunization status   |
| 74. spiritual beliefs                                       | 94. addictive behaviors   |
| 75. patient preferences/habits                              | 95. ability to socialize  |
| 76. sexual behavior   | 96. other   |
| 77. safety  | 97. visual/spatial ability  |
| 78. patient/family wishes                                   | 98. disruptive behavior   |
| 79. community mobility                                      | 99. nutritional status  |
| 80. caregiver education                                     | 100. exercise regimen   |
| 81. previous coping abilities                               | 101. toileting  |
| 82. knowledge of community resources and ability to access  | 102. behavior (i.e., agitated, assaultive, noisy, demanding, withdrawn) |
| 83. skilled professional care needs (frequency and purpose) | 103. recent losses  |
| 84. X-ray, laboratory results                               | 104. durable medical equipment  |
| 85. swallowing deficits                                     | 105. delusional thinking  |
- 

### Categorizing assessment content

Items within assessment instruments are often grouped by section or domain to structure related information in an organized manner. Sorting assessment information according to categories facilitates the process of clinical decision-making and enhances administrative utility. The Panel was determined to create a structure for the instrument that could be easily integrated with commonly recognized discharge planning systems and procedures. The Panel considered the needs assessment within the context of the broader discharge planning process in

organizing the sequence for the various sections of the UNAI. An attempt was made to relate the organization of the instrument to the typical flow of the needs assessment process, ordering sections as they might be chronologically addressed throughout the episode of care. The Panel selected eight categories and placed them in the following sequence:

- o Sociodemographics
- o Health Status
- o Functional Status
- o Environmental Factors in Post-Discharge Care

- 
- o Nursing and Other Care Requirements
  - o Family and Community Support
  - o Patient/Family Goals and Preferences
  - 0 Options for Continuing Care

### **Defining terms and measurement methodology**

Having established the above categories and sorted prioritized items under the appropriate headings, the Panel turned its attention to a number of tasks necessary to operationalize an assessment of needs for continuing care. This process entailed developing specific language to characterize each item on the instrument, defining the scope and intent of each item being assessed and determining the means by which the item would be measured. The Panel drew substantially upon the professional knowledge and expertise of its members in constructing the instrument and establishing assessment methodology.

In designing the UNAI, the Panel endeavored to make the form as user-friendly as possible. The level of detail needed to enhance inter-rater reliability was discussed at great length. The Panel believed that the instrument should use language recognized by discharge planners and other potential users, regardless of their professional training or discipline. For the UNAI to have an acceptable level of inter-rater reliability, discharge planners must have a common understanding of the assessment criteria included in the instrument.

Despite this objective, the Panel did not wish to sacrifice the accuracy that can be achieved by

incorporating clinical terminology commonly utilized by a specific discipline(s). The terminology adopted in each assessment domain tends to reflect the frame of reference particular to the discipline most commonly associated with assessing those spheres. For example, the **Nursing and Other Care Requirements** section borrows significantly from the framework and terminology used in nursing practice. Similarly, the **Functional Status** section uses language and definitions common to the rehabilitation provider community. The Panel streamlined and simplified the language of assessment domains as much as possible, but stressed the importance of the assessor manual, training and professional supervision to promote consistent use of terminology.

The Panel debated the advantages and disadvantages of two general approaches to formatting the instrument. One scenario would have the instrument include a detailed definition and numerous cues or examples for each item. Additional space would be provided for relevant comments or extenuating factors to be considered by the assessor. On the positive side, this format would provide the assessor with all the information necessary to understand the items and accurately complete the assessment. Using this approach, the amount of supporting documentation and training required to administer the instrument properly would be minimized. However, on the negative side, the length of this type of document may overwhelm potential assessors, and be cumbersome to utilize and maintain.

---

An alternative format approach would not provide any explanatory detail on the assessment form itself but would rely on a user's manual to provide the definitions and directions needed to administer the instrument. The user's manual would serve as a reference tool for UNAI assessors, providing explanations of the instrument's organization and content, and instructions governing its appropriate application. The manual would include supporting documentation, such as definitions, cues and examples, designed to promote consistency and uniformity in the assessment process.

A potential disadvantage to this approach might be the frequent need for assessors to reference the manual during the assessment process, thus increasing the administration time. Lack of consistent availability of a user's manual to the patient care team members was also viewed as a potential problem with this approach. The Panel recognized that this approach would probably require more extensive training of assessors. This was a particularly important consideration given the widespread use of temporary personnel, in some areas of the country, in positions likely to be utilizing the UNAI.

The Panel eventually adopted a format that sought to strike a balance between the interests of minimizing the length of the instrument and providing sufficient detail to allow the form to stand alone. Only those definitions and cues that were deemed critical were included on the needs assessment form itself.

Specific decisions on UNAI content and format are elaborated upon section by section following the instrument, which is presented in Exhibit 4-2.

## B. SCOPE OF THE NEEDS ASSESSMENT

In developing specific content, the Panel operated under the following assumptions regarding the scope and intent of the items to be included in each assessment category:

- o **Sociodemographic:** Basic identifying information.
- o **Health Status:** Information on a limited number of conditions and risk factors felt to be predictive of the need for post-hospital care.
- o **Functional Status:** Evaluates the level or degree of independence in performance of activities fundamental to daily living. The functional assessment is intended to provide a measure of functional competence and efficiency and to determine the patient's self-care abilities and need for assistance or supervision.
- o **Environmental Factors:** Identifies the patient's usual living arrangements and specific barriers in the anticipated post-hospital environment that may affect the patient's ability to safely realize his or her self-care potential.
- o **Nursing and Other Care Requirements:** Predicts or extrapolates the professional services, supplies, and/or equipment that will be required by the patient







# EXHIBIT 4-2

## III. FUNCTIONAL STATUS

See manual for complete definitions and instructions, Rate observed or reported performance only. Rating assumes patient is able to function safely.

### A. Rate Level of Independence for the Following:

(Minimal assistance defined as including the need for supervision, verbal cueing or minimal physical assistance. Moderate assistance implies the need for physical assistance.)

#### Activities of Daily Living

	Independent	Minimal Assistance	Moderate Assistance	Dependent	Assistive Device(s) Needed to Perform Activity
Eating (ad of bringing food to mouth, chewing and swallowing)					
Bathing (bathing <b>body</b> , excluding back and shampooing hair)					
Dressing (setting out clothing and dressing entire body, including necessary <b>prosthesis/orthosis</b> )					
Toilet Use (use of toilet, urinal, bedpan; includes cleansing self after elimination and adjusting <b>clothing</b> )					
Bowel Management (intentional control d bowel movements; includes use of agents necessary for bowel <b>control</b> )					
Bladder Management (intentional control d urinary bladder; includes use of agents necessary for bladder control)					
Transfer (transferring to and from bed, chair or wheelchair; includes coming to a standing position)					
Locomotion (includes walking, once in a standing position; using a wheelchair indoors)					

### B. Additional Assistive Devices Currently In Use:

- ☐ Glasses  
☐ Dentures  
☐ Hearing Aid  
☐ Other \_\_\_\_\_

(Specify)

### C. Instrumental Activities of Daily Living (complete only if considering return to a community residence):

	Independent	Needs Assistance	Unknown
Meal Preparation (includes cooking food and setting up meal)			
Medication Administration			
Telephone Use			
Housekeeping			
Shopping			
Handling Finances			
Transportation Use			

Check most frequent mode d locomotion at discharge: ☐ Walking ☐ Wheelchair

### D. Communication

Comprehension (Ability to understand auditory or visual communication)

- ☐ Able to understand directions  
☒ Can follow directions with minimal prompting, repetition  
☐ Has difficulty following directions, needs constant prompting  
☐ Unable to **follow** simple directions

Expression (Ability to communicate basic daily needs)

- ☐ Expresses needs clearly  
☐ Expresses needs **slowly** or requires minimal prompting  
☐ Expresses needs with difficulty, requiring much prompting  
☐ Unable to express needs

Usual Mode(s) of Communication

- ☐ Speech  
☐ Writing  
☐ Gestures/Sounds  
☐ Sign Language  
☐ Communication Device

### E. List Restrictions that Would Affect Ability to Perform Above Functions:

## IV. ENVIRONMENTAL FACTORS IN POST-DISCHARGE CARE

### A. Usual Living Arrangements:

- ☐ House/Apartment  
☐ Rented Room  
☐ Board and Care/Personal Care Facility/Retirement Home  
☐ Nursing Facility  
☒ Other \_\_\_\_\_

- ☐ Alone  
☐ With Spouse  
☐ With Others (Specify) \_\_\_\_\_

Are noninstitutional living arrangements available? ☐ Yes ☐ No

### B. Environmental Barriers

Comments:

	Yes	No
Are there barriers to building entry/exit?		
Are there internal barriers (stairs, narrow doorway)		
Is toilet/tub/shower accessible?		
Is the patient able to access emergency assistance?		
Other Barriers (Specify):		

# EXHIBIT 4-2

## V. NURSING AND OTHER CARE REQUIREMENTS

Check Anticipated Needs for Continuing Care:

### A. Therapeutic Needs:

1. Skin: ☐ Pressure Ulcer Care: \_\_\_\_\_ Stage \_\_\_\_\_ Site ☐ Drainage/Culture Care: \_\_\_\_\_

☐ Wound Care: \_\_\_\_\_ Stage \_\_\_\_\_ Site ☐ Drainage/Culture Care: \_\_\_\_\_

2. Nutrition: ☐ Therapeutic Diet (Specify) \_\_\_\_\_

c I Enteral Feeding: ☐ Nasogastric ☐ Gastrostomy Frequency: \_\_\_\_\_

☐ Parenteral Feeding: Frequency: \_\_\_\_\_

3. Hydration: ☐ Encourage Fluids ☐ Restrict Fluids

c I Intravenous Hydration Route: ☐ Peripheral ☐ Central

Frequency: \_\_\_\_\_

4. Respiratory: CI Oxygen: ☐ Continuous ☐ Intermittent Frequency: \_\_\_\_\_

Delivery Method and Liter Fbw: \_\_\_\_\_

☐ Tracheostomy: ☐ Temporary ☐ Permanent Frequency of Care: \_\_\_\_\_

☐ Suctioning: Frequency: \_\_\_\_\_

☐ Ventilator: ☐ Temporary ☐ Permanent

5. Elimination: ☐ Urinary Catheter: ☐ Indwelling ☐ Intermittent

Size: \_\_\_\_\_ Insertion Date: \_\_\_\_\_ Irrigation and Frequency of Care: \_\_\_\_\_

☐ Ostomy: Type and Frequency of Care: \_\_\_\_\_

☐ Dialysis: ☐ Hemo ☐ Peritoneal ☐ CAPD Treatment Frequency: \_\_\_\_\_

### 6. Administration/Management of Medications:

☐ Oral

☐ Subcutaneous/Intramuscular: Frequency \_\_\_\_\_

☐ Intravenous: ☐ Antibiotics ☐ Chemotherapy ☐ Blood Products

Frequency: \_\_\_\_\_

☐ implanted Pump: Frequency: \_\_\_\_\_

☐ Other: \_\_\_\_\_

7. ☐ Skilled Nursing Observation: \_\_\_\_\_

8. ☐ Supervision/Evaluation: \_\_\_\_\_

9. ☐ Other Care Needs: \_\_\_\_\_

### B. Patient/Family Educational Needs:

- ☐ Self-Care Activities
- ☐ Self-Management of Illness
- ☐ Diet Instruction
- ☐ Medication Administration
- ☐ Ostomy Care
- ☐ Wound Care/Dressing Change
- ☐ Tracheostomy Care/Suctioning
- ☐ Other \_\_\_\_\_

## VI. FAMILY AND COMMUNITY SUPPORT

### A. Source(s) of Support:

Primary Support	Relationship	Type of Support (physical, psycho- logical, social and/or economic)	Availability	Limitations or Constraints
Name: _____				
Address: _____				
Phone: _____				
Other Caregiver: _____				
<input type="checkbox"/> No Known Support				

### B. Community Services Utilized Prior to Admission:

Home Health Services \_\_\_\_\_

Homemaker Services \_\_\_\_\_

Equipment/Supplies \_\_\_\_\_

Meals to Homebound \_\_\_\_\_

Transportation \_\_\_\_\_

Adult Day Care \_\_\_\_\_

Mental Health Services \_\_\_\_\_

Hospice \_\_\_\_\_

Respite \_\_\_\_\_

Case Management \_\_\_\_\_

Other \_\_\_\_\_

### C. Additional Assistance Needed (For Home Care):

D. Physician Responsible for Follow-up Care (Name/Phone No.):

E. Other Individual Responsible for Coordinating Care (Name/Phone No.):

# EXHIBIT 4-2

## VII. PATIENT/FAMILY GOALS AND PREFERENCES

### A. Patient's Goals and Preferences for Continuing Care:

---



---



---

### B. Family/Caregiver's Preferences for Continuing Care:

---



---



---

### C. Religious or Ethnic Practices that May Affect Needs or Preferences for Continuing Care:

### D. Decision-Making Support:

	Already Has	Desires/Requires
Durable Power of Attorney for Health Care Decision-Making	<hr/>	<hr/>
Living Will .....	<hr/>	<hr/>
Guardian/Conservator .....	<hr/>	<hr/>

### E. Surrogate Decision-Maker (Name/Phone No.):

## VIII. OPTIONS FOR CONTINUING CARE

### A. Therapy/Service Needs:

<input type="checkbox"/> Nursing	<input type="checkbox"/> Respiratory Therapy
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Social work
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Other <hr/>

### B. Durable Medical Equipment/Supply Needs:

<input type="checkbox"/> Bed	<input type="checkbox"/> Siderails	<input type="checkbox"/> Trapeze	<input type="checkbox"/> Commode
<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Oxygen	
<input type="checkbox"/> Other:	<hr/>		
<input type="checkbox"/> Durable Supplies:	<hr/>		

### C. The Following Options are Consistent with the Patient's Needs:

<input type="checkbox"/> Home (no additional services necessary)	<input type="checkbox"/> Other community services (specify Type ) <hr/>
<input type="checkbox"/> Relative's home	<input type="checkbox"/> Rehabilitation facility
<input type="checkbox"/> Home with home care services	<input type="checkbox"/> Board and care/personal care facility/retirement home
(Specify Type <hr/> )	<input type="checkbox"/> Nursing Facility
<input type="checkbox"/> Outpatient (Specify Type ) <hr/>	<input type="checkbox"/> Hospice
<input type="checkbox"/> Adult day care	

### D. Needs/Options Have Been Discussed with:

☐ patient

☐ family/representative

☐ not discussed

Remarks:

Discharge Planner/Coordinator's Signature:

Date:

---

upon discharge from an acute or long-term care setting.

- o **Family and Community Support:** Identifies potential caregivers and evaluates their ability to provide support to the patient as well as the supplementary resources that are available in the patient's community.
- o **Patient/Family Goals and Preferences:** Incorporates the values and desires of patients and their families necessary to develop options to meet continuing care needs. The framework is intended to facilitate patient and family participation as well as promote self-determination within the discharge planning process.
- o **Options for Continuing Care:** Identifies potential options for disposition and suggested continuing care services.
- o **Attestation of Patient/Family Involvement in Assessment of Continuing Care Needs:** Provides for acknowledgement by the patient and family of their participation in the assessment process. (This section will be attached to the UNAI but printed as a separate form.)

## C. SOURCES OF INFORMATION AND INTERDISCIPLINARY CONTRIBUTIONS TO THE NEEDS ASSESSMENT

The Panel viewed the UNAI as drawing together information through a number of different means and utilizing a variety of sources. The process in which the information is collected for

the assessment may vary by institution. One organization may utilize an individual social worker or nurse discharge planner to interview and observe the patient and family, consult with medical, nursing, rehabilitation and other professional staff and complete the instrument based on this interdisciplinary input. Another approach may involve several different disciplines assuming responsibility for completing specified components of the tool. The Panel, as reflected in the recommendations summarized in chapter 5 of this report, strongly suggested an interdisciplinary process as the most desirable system for achieving an accurate and complete picture of the patient's needs. At the same time, the terminology on the UNAI form should be understandable regardless of the assessor's background or professional training. In addition, the Panel viewed the "coordination" of the needs assessment as critical to the process of consolidating previously documented information and soliciting input directly from team members.

### Sources of information

Throughout its deliberations, the Panel identified three principle sources for assessment information:

- o Clinical records. Using the patient's clinical record as a source of information has several advantages. Clinical records are accessible, contain assessment data generated by trained personnel familiar

---

with a patient, and are usually presented in a universally recognized language and format. On the other hand, the transfer of information from the clinical record to the UNAI might result in information being miscopied, misinterpreted, or out-of-date. The Panel emphasized that the assessor should document only those medical conditions that are active or could have an impact on future care needs.

- o Direct clinical observation. There was a certain sentiment held by the Panel that direct observation of the patient by a clinical professional was the most accurate and desirable method for completing the instrument. Relevant information about complex and chronic conditions that affect aftercare decisions cannot always be captured through record review. Clinical observation alone may not capture the presence of underlying medical conditions or important risk factors, unless the assessor's attention is specifically directed to those factors. Elderly patients, in particular, may have chronic health problems that will not be observed by hospital staff unless the patient was admitted specifically for treatment of that problem. The types of problems that frequently go unobserved are often problems that may significantly decrease a patient's post-hospital functioning. Mouth ulcers, which often prevent a patient from eating, are a classic example. The background and expertise of the observer may also influence the reliability of assessment information. Cognitive and behavioral issues, for example, may be misinterpreted by an assessor with little or no mental health training.

- o Patient and family interviews. Patients and their families can share important information regarding patient capabilities, idiosyncrasies, and preferences otherwise unknown to professional caregivers. However, reported information has potential drawbacks: it will probably not be framed in clinical language, and it is possible that patients and their families may, unintentionally or otherwise, distort the information to influence decisions or recommendations regarding the discharge plan. Such distortions might take the form of over-representing a patient's capabilities in order to avoid the prospect of institutionalization, or exaggerating disabilities in an effort to "qualify" for desired post-hospital benefits.

Some assessment data could be collected from any source; other items may require the assessor to consult a particular source to obtain accurate and reliable information. The Panel therefore recommended that the user's manual include the most appropriate source(s) of information for relevant assessment items.

### **Interdisciplinary participation in the assessment**

The background and expertise required of assessors may also vary throughout the needs assessment process, depending upon the nature of information to be collected. **Health Status** information, for example, would be provided by the patient's attending physician(s) and is generally available within the admission history and physical or progress notes. **Functional Status**

---

would ideally be evaluated through direct observation by a nurse, therapist, social worker, or discharge planning professional. However, in some cases, it may have to be obtained through reports from family members or other caregivers. **Nursing and Other Care Requirements** data will draw substantially from the nursing assessment, but will likely include input from other clinical professionals as well. Information regarding **Family and Community Support** is frequently identified through a social work evaluation, but may also be supplied by other members of the health care team.

#### D. ISSUES IN CONTENT

The following summarizes the Panel's deliberations leading to decisions regarding inclusion or exclusion of potential assessment items:

##### **Sociodemographic information**

Some type of demographic information is traditionally included on all patient assessment forms. The Panel agreed that the majority of information relevant to an assessment of continuing care needs is typically available as part of the patient's admitting information (e.g., on the admission face sheet.) Concerned with the potential for duplication of information contained on other forms or records, the Panel recommended that the assessor attach an admission face sheet to the UNAI and complete only those items not found on the attachment.

The Panel considered a number of reasons to include sociodemographic information on the UNAI:

- o At a practical, administrative level, certain information may be necessary to identify a patient and to ensure that each assessment is correctly labelled. Such identification may be necessary if the information is to be transferred to a post-hospital care provider or utilized by third party payers in determining eligibility for services. Various patient identifiers may also be needed to link assessment forms to other patient records.
- o Certain sociodemographic information is clinically relevant to an assessment of continuing care needs. Factors such as age, marital status and religious preference may impact on such continuity of care issues as access to services and community support systems.
- o Demographic information may also be useful for research purposes. For example, small-area analysis may use patient ZIP codes to sort patient records by geographic regions. Other analyses might require information such as patient age, place of birth or educational level. The Panel determined, however, that socio-demographic information should be included in the UNAI only to the extent that it contributes to the needs assessment. No demographic items were added to the instrument for research purposes alone.

The potential items "health care coverage" and "income level" generated particularly intense Panel debate. The Panel acknowledged the



---

importance of financial resource information in determining the availability of post-hospital services. There was, however, significant concern expressed about the potential use of such information to discriminate against patients with limited resources. The Panel believed strongly that the assessment of needs should not be influenced by an individual's financial resources. An individual's ability to pay for recommended services was viewed as more appropriately assessed at the point that continuing care options are evaluated to formulate the discharge plan. In reaching a consensus, the Panel attempted to balance the perceived value of insurance coverage information with its apprehension about potential bias against patients with limited financial resources. The Panel thus agreed as a compromise position to include third party payer information generally available in the patient's record, but to exclude data related to income level or financial status.

Another issue of debate was the inclusion of items on "education", "race", and "religion" in this section. The majority of the Panel believed these areas are relevant in assessing the patient's health care needs. The patient's race, religion and educational background can be used to identify specialized needs, enabling the health care provider to match the patient with the most appropriate services. Considerations such as the need to seek placement in a facility that provides the patient cultural and ethnic commonality or the patient's capacity to learn complex instructions for self-care may be identified through

information of this nature. Some panelists expressed the concern that such information could potentially be used to discriminate against patients on the basis of race, religion or education; they preferred that cultural or religious issues be addressed in a different manner. One suggestion involved addressing information regarding cultural or religious practices within the section of the instrument devoted to **Patient/Family Goals and Preferences**. An item could focus on related issues that the patient/family volunteer as relevant to their aftercare, rather than asking all patients questions they may perceive as a violation of privacy. However, the decision to retain items to assess race, religion and education reflected the Panel's consensus on the importance of such information in determining individualized needs and/or appropriate resources.

The Panel recommended that those responsible for coordinating the completion of the assessment verify the patient's health care insurance coverage. Insurance status may change during an episode of care and requires periodic updating. The transfer of incorrect coverage information can have unfortunate consequences, for both patient and provider.

### **Health status**

The Panel did not believe that exhaustive diagnostic information regarding the patient's health status was necessary to determine continuing care needs. The **Health Status** assessment is not intended to be a complete clinical review of

---

a patient's physiological or psychological systems. A complete review may be summarized elsewhere in the patient's medical record; the discharge planner reviews this information to abstract that which is relevant to the needs assessment and formulation of a discharge plan.

Concerns were expressed regarding potential redundancy in the collection of health status data. The Panel acknowledged that numerous patient histories are performed routinely as a part of the admission assessment process and ongoing clinical evaluation. The physician's history and physical and initial nursing assessment, for example, are likely to identify the majority of health problems that are referenced in the UNAI.

The Panel concluded, however, that the importance of summarizing those health factors that were predictive of needs for continuing care outweighed concern regarding duplication of previously collected information. The Panel attempted to develop a minimal list of factors (medical conditions and behaviors) that place the patient at increased risk of needing formal or informal supportive care. Directions on the UNAI form instruct the assessor to indicate only those factors that may affect post-discharge care needs. This instruction was intended to preclude the inclusion of information about inactive conditions that would only confuse the assessment process by adding unnecessary data.

Throughout its deliberations, the Panel expressed concern about potential abuses of sensitive data contained on the UNAI. Members underscored the importance of clearly defining

the purpose, content and limitations of the assessment and carefully controlling the use of data. For example, several cognitive/behavioral factors within the health status section of the assessment contain particularly sensitive patient information. Judgments of behavior are inherently subjective. Furthermore, impairment of a patient's cognition and/or behavior may be a normal, transient response to an unfamiliar and stressful environment, or to physiological and psychological attributes of an illness, disease or treatment. For example, many postoperative patients are unaware of the date; many persons recently diagnosed with cancer are anxious or depressed, and patients with diminished kidney function may have temporary symptoms of an organic psychosis.

The Panel was therefore concerned that the UNAI might inappropriately label a patient and result in unnecessary restriction of continuing care options or other forms of discrimination against the patient. To avoid such situations, here and elsewhere, the Panel believed that the appropriate uses and limitations of the UNAI should be delineated in the proposed UNAI assessor's manual.

### **Functional status**

Classical functional assessment tools, such as Katz's Index of ADL, have dominated the assessment field, perhaps because functional assessment has clearly defined methodology and numerous clinical applications. Many of the

---

factors identified by the Panel as potential assessment items describe a patient's ability to function or engage in activities necessary to care for him- or herself. In fact, several items assessed in diagnostic, therapeutic or environmental terms and placed in the **Health Status, Nursing and Other Care Requirements**, and/or **Environmental Factors** sections of the UNAI could have also been effectively addressed in a functional context. Some panelists believed that these items should have been evaluated in terms of functional performance rather than from a different perspective elsewhere in the UNAI.

In the interest of efficiency, the Panel's ideal was for the discharge planner to assess patient characteristics only once; this type of overlap appeared to threaten that ideal. The Panel finally determined that while there was typically an appropriate domain in which to assess each patient characteristic, some attributes should be addressed from more than one perspective. Communication, for example, is addressed from both a cognitive perspective' in the **Health Status** section and in functional terms. The discharge planner needs to know the patient's ability to understand and follow directions as well as the patient's ability to communicate. The sometimes competing objectives of standardization and precision presented a challenge to the Panel in establishing an accurate but practical rating scale for functional assessment items.

The Panel discussed a range of benefits and liabilities resulting from different scaling approaches to functional assessment:

- o A very sensitive scale is desirable because it describes the patient's needs for care most accurately. However, the assessor may not be able to use a complex rating system reliably. Inter-rater reliability often decreases when there are many discreet levels and raters are allowed more options.
- o A symmetrically graduated ("interval") scale, such as a Likert scale, produces data that is easier for researchers to manipulate. An interval scale assumes an equal distance between each level and would allow a numerical summation of ratings for the various items. Levels of functional ability do not translate neatly to an interval scheme, however, and such scales may also be more difficult for users to interpret.
- o An ordinal level scale with a limited choice of responses such as dependent/independent or low, moderate, and significant impairment may be easier for the assessor to use and provide more reliable data. However, the information may be inadequate to determine specific needs for support or assistance.
- o It would be desirable, for ease of use as well as research purposes, for the instrument's terminology and scaling to match or approximate the scaling of the various assessment instruments used in hospitals and other settings (see chapter 3.)

The Panel debated the merits of various types of scales and ultimately settled on a four point scale to rate a patient's functional capabilities:

- 
- o **Level 1 - Independent**
  - o **Level 2 - Minimal Assistance**  
defined as the need for supervision,  
verbal cueing and/or minimal physical  
assistance
  - o **Level 3 - Moderate Assistance**  
limited to need for physical assistance  
only
  - o **Level 4 - Dependent**

This scale was regarded as the optimal approach to determining the nature of functional assistance that may be required by a patient. The Panel initially considered including a tripartite subset for **level 2** to further differentiate between required types of assistance (i.e., supervision, cueing or minimal physical assistance) as well as a level to evaluate the need for extra time and/or assistive devices. However, this scale was felt to be overly complex and unnecessary for the level of assessment needed to determine continuing care needs. The rating scale adopted by the Panel does incorporate a measure of a patient's need for assistive devices by providing space for such a notation beside each activity.

Instrumental Activities of Daily Living are arranged in a grid format consisting of **Independent**, **Needs Assistance**, and **Unknown**. A section will also be provided to list restrictions that would affect a patient's ability to perform these activities. This is intended to accommodate such medical instructions as "complete bedrest" that would qualify an independent rating on **Locomotion**.

Cues describing the scope of each item are included on the instrument to facilitate consistent interpretation among assessors. The Panel recommended that detailed definitions and examples for each ADL item and level of function be provided in the proposed user's manual.

### **Environmental factors in post-discharge care**

In this section and those following, the focus of the UNAI shifts from patient characteristics and capabilities to an evaluation of an individual's proposed post-discharge environment and sources of support. The items contained in the **Environmental Factors** section attempt to identify the patient's previous living situation as well as conditions that may prohibit discharge to that environment.

The Panel sought to structure items related to the environment in terms that would yield an objective and useful response. It was recognized that discharge planning teams must make a preliminary assessment of the adequacy of the proposed post-hospital environment in determining the feasibility of the discharge plan. Such items were incorporated in the UNAI. However, the Panel realized this evaluation of a patient's environment is based on limited, self-reported information and is primarily a cursory exploration of possible physical barriers or obstacles. A more thorough evaluation, based upon a home visit, may be preferable, depending upon the complexity of the patient's continuing care needs.

---

As with other sections of the instrument, the Panel originally identified additional areas that could be assessed. However, the items in the **Environmental Factors** section are intended to provide the minimum information required to assist the patient and family to begin identifying environmental options and resources.

The Panel addressed liability concerns in deliberating content regarding the post-hospital environment section. Although legal issues are given a thorough treatment in chapter 6, they are outlined here in relation to this section of the instrument. Assessment questions regarding the presence of possible environmental barriers may identify certain conditions, which if not addressed, may result in a risk to patient health and safety. The Panel considered whether documenting knowledge of postdischarge impediments would increase a health care facility's exposure to liability. There was concern that by identifying environmental risks, the provider might be held responsible for making suggested modifications. The attorney who advised the Panel suggested that an institution's obligation probably would not extend beyond identifying barriers and suggesting resources or alternatives to address those issues (S. Mitchell, Panel presentation, December 8, 1988).

### **Nursing and other care requirements**

Since a majority of the items in this domain involved aspects of nursing practice, the Panel assumed that the staff registered nurse, drawing upon the attending physician's prescribed plan of care<sup>1</sup>, would be a primary source of information for identifying continuing care requirements. Information regarding nursing care requirements could be assessed directly by a physician, staff nurse or nurse discharge planner, or communicated verbally or via the clinical record to a non-nurse discharge planner. Other needs for professional service or therapy would likely require consultation with relevant disciplines, such as nutritionists (therapeutic diet), respiratory therapists (oxygen), or pharmacists (intravenous antibiotics).

Although panelists substantively agreed on content, particular difficulty was experienced in establishing the language and format of the **Nursing and Other Care Requirements** section. Two alternative formats were considered. The first involved an inventory of physiological systems and provided an open-ended framework to document additional information at whatever level of detail was available and appropriate. Advantages to this type of format included the comprehensive nature of a systematic approach, the potential to minimize omission of significant

---

<sup>1</sup> A basic assumption of the Panel was that needs assessment data compiled via the UNAI would be consistent with the course of treatment or therapies prescribed by the responsible medical practitioner. While a variety of

disciplines may participate in the needs assessment process with recommendations for continuing care developed by a multidisciplinary team, the physician is ultimately responsible for the discharge/continuing care plan.

---

data, and the flexibility to include as much or little information as was clinically warranted. A second approach utilized a more detailed menu of therapeutic needs that typically require some level of patient teaching/preparation and/or follow-up care. Such a format would involve a checklist design rather than the more open-ended narrative response.

Guidance or cues were considered necessary for the non-nurse discharge planner to complete this section of the instrument. The need for detailed and technical information regarding care and treatment would require either version to be performed and/or supervised by a knowledgeable professional. After reviewing drafts of both versions, the Panel adopted a third alternative that combined the perceived strengths of both approaches. The adopted format is organized around key sub-systems (e.g., respiratory, elimination, nutrition), but provides specific subheadings and cues designed to structure responses according to typical areas of need.

The issue of timing of the assessment (see Chapter 5) was revisited in relation to the period for which care needs are being assessed. Panelists believed that this assessment would contain different material if the assessor documented current needs for care versus those needs the assessor predicted would continue post-discharge.

Panelists were also concerned about the hazards of transferring wrong or outdated information. Medications, for example, would probably differ significantly depending upon when the assessment was completed. At the onset, the

Panel decided to assess needs for non-oral medication administration, such as intravenous antibiotics or other medications, chemotherapy, and subcutaneous or intramuscular injections. There was also significant concern among panelists about the possible adverse impact of multiple medications on health care outcomes. For this reason, a number of Panel members advocated to include a listing of oral medications in the assessment.

While this position was supported conceptually, it was viewed by a majority of panelists as unrealistic given the changes routinely made from medications administered during the hospitalization to those prescribed after discharge. It was felt that the timing of the assessment process would likely preclude accurate information about oral discharge medications. Intramuscular or intravenous administration was viewed as easier to anticipate for continuing care purposes. The Panel concluded that the “medications” item should be assessed from the perspective of whether assistance was needed to administer and/or manage medications. Cues to assess care needs in terms of route and frequency of administration were added to the form.

To clarify the period for which care needs would be assessed, the Panel proposed to include in the user’s manual the following supplementary information related to the timing of the **Nursing and Other Care Requirements** section:

- 
- o The assessment does not include current care needs for those patients in an acute care setting, but is based only on the prediction of needs that will continue post-hospitalization.
  - o Assessments performed in care settings other than the hospital include current needs (i.e., to determine if there is a need for continuing care in that particular setting or whether the patient now has additional options.)

### **Family and community support**

In the enabling legislation, the Panel was specifically enjoined by Congress to include a measure of the support available to the patient in meeting his or her needs, including social and familial resources. As the Panel worked on other assessment areas, the importance of this assessment domain became increasingly clear. The UNAI assessor's efforts to measure the nature and extent of patient's needs would be irrelevant if no resources exist to meet those needs. The **Family and Community Support** section of the UNAI is patient centered, as are all other sections, but begins to consider the patient within the context of his or her social network.

In selecting the actual items and format for the section on **Family and Community Support**, the Panel recognized that the majority of continuing care assistance is provided by family caregivers. For this reason, it was considered essential to identify all principle sources of support and evaluate their availability and capability

to meet the patient's assessed needs. There was acknowledgement that individuals proposed as caregivers may have the desire and intention to provide assistance but lack the time or physical capability required to render necessary care. Conversely, a patient may identify a family member whom he or she is depending upon for assistance, but the relative is unwilling to provide the needed support. The Panel concluded that it was necessary to assess the viability of proposed caregivers in terms of both availability as well as limitations to their involvement.

The importance of the patient's support network in the development of options for continuing care is better understood when examining the considerable geographical variation in the availability of formal and informal resources. For example, a hospital in an isolated rural area may rely largely on family and/or extended family networks in the absence of formal community services. In this case, the capacity of family and friends to provide assistance to the patient may dictate the options for post-discharge disposition. Conversely, in a large intercity public hospital, the discharge planner is more frequently confronted with the patient with "no known support" and/or "no place of residence", increasing dependence on specialized community services and creativity in constructing a plan for community based care.

In determining which items to include in this section related to community services, the Panel concluded that "services utilized prior to admission" may be most predictive of the type of

---

services required after discharge. In addition, specific information related to the provider of prior services would facilitate continuity of care if such service needed to be reinstituted.

The physician(s) and other professionals responsible for continued medical management and coordination of continuing care are also identified in this section of the assessment.

### **Patient/family goals and preferences**

This section of the assessment is intended to focus the assessor on the patient's and family's goals and preferences for continuing care. Factors such as where the patient intends to reside and expectations regarding his or her ultimate level of independence are examples of questions that are explored within this domain. There was consensus among Panel members that the patient and family are the ultimate decision-makers in planning for continuing care. In this context, the role of the health care team is viewed as identifying needs and resources as well as presenting various care options to the patient and family. If a patient's preferences or expectations are unrealistic or conflict with the availability of the identified caregiver or services, it is the responsibility of the health care professional to address the potential consequences of the patient's preferred plan of care and facilitate open communication and informed decision-making.

In addition, the Panel felt it was important to clarify the capacity of the patient to make an informed decision and to identify the need for or

presence of any delegated surrogate (i.e., durable power of attorney, conservator or guardian.) Knowledge of "advanced directives" is an important aspect of assessing goals and preferences. Members of the Panel viewed the inclusion of items related to goals and preferences for continuing care as critical to patients' self-determination and patient centered discharge planning.

### **Options for continuing care**

A majority of the Panel believed it was necessary to add a section to the instrument that summarizes the assessment findings and identifies continuing care options. The summary would include a listing of alternative dispositions and suggested therapeutic and support services based on the assessment findings.

A number of panelists expressed the concern that the summary section moved the assessor into a different stage in the discharge planning process, that of "plan formulation." While there was general agreement that planning should logically follow from the needs assessment, many felt that this process went beyond the Panel's charge. Other panelists advocated for a more extensive consideration of options and the inclusion of a proposed discharge plan. Discussion also addressed the need for development of a decision-making methodology to establish a systematic process linking assessment data to a predictable continuing care plan. An algorithm could be devised in which a needs assessment score or rating would be translated into disposition and



---

service recommendations. Panel members agreed that development of such methodology, while potentially desirable, would require advances in assessment technology beyond the Panel's scope and resources. The Panel ultimately agreed that the final section of the UNAI would include a summary of options that would begin to synthesize the assessment data but stop short of establishing a definitive plan for continuing care.

The Panel considered recommending the maintenance of a prototypical community services directory within the health care facility to ensure that discharge planners have available a comprehensive reference for community health and social services. Panelists also believed that use of a standardized directory would reveal significant gaps in the availability of post-hospital services and provide valuable data for efforts to change policies that govern access to such care. The Panel finally determined that such a proposal, although potentially useful, was beyond the scope of the Panel's charter and duplicated available community based information and referral systems that could supplement and extend a hospital's own data base.

#### **Attestation of patient/family involvement in assessment of continuing care needs**

The issue of including a signed acknowledgement by the patient attesting to his or her participation in the assessment process was debated at length. Deliberations centered around the necessity of such a process, when the attesta-

tion should occur and what such a signature would mean. Divergence of opinion on this issue reflected differing views of the nature of discharge planning, the role of the UNAI in the discharge planning process, and the most appropriate method to document patient/family involvement in the needs assessment process.

Some Panel members believed that requiring the patient's signature on the assessment would reinforce the patient's right to participate in the needs assessment and decision-making process. Attestation was seen as a method to structure patient/family involvement as well as raise the awareness and attention of professionals to the central role of the patient in health care decision-making. An attestation process was also viewed as an opportunity to review with the patient the information gathered during the assessment process and the alternative options for post-discharge care. Panelists argued that, without patient review and approval of assessment data, inaccurate information could be included in the UNAI that might adversely affect the appropriateness of the care plan and the post-discharge quality of life.

Other Panel members believed that the completion of the UNAI should not require patient attestation. This group agreed that the patient must be at the center of the discharge planning process, and supported the patient's involvement in the needs assessment. However, they questioned whether patient attestation would achieve this purpose, believing that it could actually be detrimental to the patient-provider relationship.

---

Principally, there was concern that the purpose and meaning of the signature would be unclear to patients and their families. Members questioned whether patients would perceive the process of signing the UNAI as approval of the discharge plan, an acknowledgement that assessment information was accurate, or a guarantee that all needed services would be made available. Secondly, it was felt that information collected on the UNAI might be detrimental to the patient if shared. For example, an assessment of caregiver availability may betray the confidence of the family members providing input and create tension and conflict between the patient and his or her significant other. Additionally, patients might refuse to sign the UNAI if unsatisfied with the care options that are identified. Members were concerned that the absence of a signature might suggest a provider's failure to meet patient care obligations and thereby increase their liability. Finally, they believed the Panel had created an instrument to fulfill the health care professional's responsibility to perform an assessment of continuing care needs, not to develop an actual discharge plan. As such, these panelists did not believe it was necessary or appropriate to have a patient's signature on the UNAI.

As with other health care services or practices, the patient's clinical record **was viewed by** these members as the most suitable method of documenting patient and family participation in the needs assessment process. Accountability could then be ensured through internal and external quality assurance review systems charged to monitor the quality and appropriateness of care.

The compromise achieved by the Panel was to develop a patient attestation form that would be attached to the completed UNAI. The attestation form would contain a brief statement indicating that the patient or representative had been involved in the assessment process. If a signature could not be obtained, the assessor would be required to indicate the reason that the patient did not sign (e.g., a comatose patient with no relatives available to sign as a surrogate). The Patient Attestation form is included in Exhibit 4-3.

### **Summary**

This chapter focused on the content and structure of the uniform needs assessment instrument. While use of the instrument may appear to be straightforward, the Panel believed that explicit recommendations regarding its administration should be delineated. The Panel also chose to record their assumptions regarding the context in which a uniform system of needs assessment could occur. The recommendations presented in the following chapter were developed by the Panel to clarify and reinforce issues regarding the use of the UNAI.

DRAFT

ADDRESSOGRAPH:

**PATIENT ACKNOWLEDGEMENT OF  
PARTICIPATION IN CONTINUING  
CARE ASSESSMENT**

Your need for care after discharge has been-reviewed. This information will be used in recommending what kind of care you need and how it can best be provided.

Your wishes and those of your family contribute important information to this review.

**By** signing in the space below, you indicate that you and your family have participated in the review of your care needs.

Signature (*Patient/Patient* Representative):

Date:

Note to assessor: If this form has not been signed by the patient or their representative, indicate reason(s) here:

---

---

---

---

---

---



---

## CHAPTER 5: RECOMMENDATIONS REGARDING THE USE OF THE UNIFORM NEEDS ASSESSMENT INSTRUMENT

This chapter supplements the previous review of content related concerns by providing a discussion of the Panel's recommendations regarding use of the UNAI. Several themes regarding the use of the instrument emerged early in the course of the Panel's deliberations. The Panel sought to clarify its assumptions regarding use of the instrument by developing specific recommendations that addressed a number of issues associated with the administration of the UNAI or the implementation of a uniform system of needs assessment. The Panel attempted to reach consensus on its recommendations on the use of the UNAI, with considerable opportunity provided to Panel members for expressing divergent viewpoints and concerns.

The Panel developed 26 recommendations in 11 categories that include: purpose of the instrument, qualifications needed by the assessor, training and uniform use, process for performing the assessment, timing of the assessment, resources necessary to administer the instrument, population to which the instrument should be administered, use of the instrument in non-acute care settings, coordination of data elements, mechanisms to ensure accountability for performance and the reliability of the assessment, and testing and evaluation. The exact text of each recommendation approved by the Panel follows, with a discussion of supporting rationale.

### A. PURPOSE OF THE INSTRUMENT

The Panel adopted five recommendations related to the purpose of the instrument that cover the following areas:

- o purpose and scope of the instrument;
- o the instrument's role in establishing uniformity and consistency;
- o the instrument's role in determining eligibility for post-hospital services;
- o the instrument's role in determining options for continuing care; and
- o considerations regarding mandating use of the instrument.

### **Recommendation #1**

The primary purpose of the needs assessment instrument should be to determine a patient's needs for continuing care. The instrument could be used to facilitate performance of the needs assessment, which is an integral part of the discharge planning process. The needs assessment is not intended to represent a comprehensive geriatric or functional assessment, or a care plan.

### **Discussion**

The responses generated during the period of field review and comment (See Appendix D) revealed varying interpretations regarding the purpose of the needs assessment instrument. Some

---

respondents considered the enabling legislation to be ambiguously worded, leaving the possible uses of the instrument open to speculation. The Panel sought to clarify its understanding of the purpose and scope of the instrument through the above recommendation.

### **Recommendation #2**

The needs assessment instrument has been developed for consideration as a uniform method of evaluating needs for continuing care across various health care settings. It is intended as a means to establish consistency and to communicate care needs in the post-acute care community.

### **Discussion**

The Panel stressed the UNAI's objective of establishing a more consistent approach in evaluating the post-discharge needs of Medicare beneficiaries. The desire for a uniform instrument is in response to concerns based upon a perceived inconsistency in the quality of current discharge planning practice and the potential for adverse patient care outcomes resulting from inadequate assessment of needs for continuing care. The recommendation also seeks to reinforce the value of an instrument that could serve to standardize the content and terminology of discharge planning assessments across various types of health care settings.

### **Recommendation #3**

The needs assessment instrument should not be used as a primary vehicle to convey information for eligibility determinations. However, the instrument could make a positive contribution to the eligibility determination process by providing a more complete picture of the patient's needs for care.

### **Discussion**

The Panel expressed its concern, shared by many in the provider community, that attempts to develop the UNAI for the ultimate purpose of determining Medicare eligibility for post-hospital services would compromise the effectiveness and validity of needs assessments. The power of the instrument to influence coverage and payment for services could create incentives to "game the system" on the part of both providers, who might seek to maximize services provided to the patient, and fiscal intermediaries, who might try to contain costs through narrow interpretation of qualifying criteria. In addition, adding items to the UNAI to gather the type and amount of information currently needed by fiscal intermediaries to determine a patient's eligibility for post-hospital services could conceivably overwhelm professionals responsible for performing the needs assessment.

However, the Panel acknowledged the concerns of providers and beneficiaries about the lack of consistency attributed to the present sys-

---

tern of eligibility determination for post-acute care. Members were hopeful that data from the UNAI could serve to supplement and support the fiscal intermediaries' decision-making process and contribute to a more objective eligibility determination process (see Chapter 7).

#### **Recommendation #4**

The needs assessment instrument is not intended to and does not contain an algorithm for determining the most efficacious option for continuing care.

#### **Discussion**

The Panel expressed apprehension about possible attempts to develop a mathematical formula associating an assessment score with specified disposition or service options. The majority of Panel members believed such an application would be premature at the very least and conceivably beyond the capacity of the instrument. Some members questioned the value of the UNAI if it did not include a method for systematically translating assessment data into a continuing care plan. The Panel, however, concluded that extensive study and testing would be required before such an algorithm should be considered, let alone developed, to achieve this end.

#### **Recommendation #5**

In the event that use of the needs assessment instrument is mandated, careful consideration

should be given to issues related to feasibility, including the resources necessary to implement such a system, the need for flexibility to accommodate variations in care settings and delivery systems, and the duplicative requirements that currently exist for reporting of patient information. These issues should be studied and recommendations developed to address them prior to implementation of a uniform system.

#### **Discussion**

In the course of its deliberations, the Panel frequently addressed the potential implications of mandating use of the instrument across the nation. Concerns expressed by members of the Panel were reinforced in the comments of numerous provider representatives asked to review the draft instrument. Resource requirements, variations in the organizational structure and capability of health care facilities and potential overlap with existing institution-specific and bureaucratic or regulatory assessment systems received particular notice. The Panel strongly suggested that a feasibility analysis should precede any legislative or regulatory decision to implement a uniform needs assessment system.

### **B. QUALIFICATIONS NEEDED BY THE ASSESSOR**

The Panel adopted one recommendation regarding the type of qualifications needed to administer the UNAI:

---

## **Recommendation #6**

Recognizing that discharge planning is an interdisciplinary effort, the uniform needs assessment instrument has been developed to be “discipline free.” Performance of the uniform needs assessment should be conducted by qualified and trained personnel without restriction to a professional group or discipline. Such personnel should be under the supervision of a registered nurse, social worker or other qualified personnel. Each health care setting would designate those individuals responsible for coordinating input and completing the assessment.

## **Discussion**

Given the Panel’s charge to develop an instrument(s) that could uniformly assess patients’ needs, the Panel believed that the instrument should be able to be used by staff members in a variety of care settings. In general, the professional assigned responsibility for discharge planning varies, depending upon an institution’s size, location, type, financial resources and other characteristics. Thus, to ensure the effective use of the instrument in a variety of care settings, the instrument must accommodate the needs and/or limitations of institution-specific programs and resources. To accomplish this, the Panel believed the instrument should be able to be used by all discharge planners regardless of discipline or professional specialty.

The Panel did not believe that any one discipline (medicine, nursing, social work, or

other) was inherently better qualified to perform the needs assessment. The Panel believed that any professional staff member could coordinate the assessment process, if properly trained in the use of the UNAI. However, because the results of the needs assessment process can affect the post-hospital services a patient receives and, consequently, the patient’s recovery and/or quality of life, the UNAI assessor should be supervised by a registered nurse, social worker or other qualified professional who has also been trained in the use of the instrument. The Panel believed this would ensure professional accountability for correct use of the UNAI and reduce the potential for an incorrect or inadequate assessment.

Several Panel members expressed different viewpoints. One panelist believed that the UNAI should be performed by a staff member(s) currently providing direct patient care; this panelist did not want use of the UNAI to impose a financial burden on health care facilities by requiring additional discharge planning staff. To this end, the panelist proposed that the UNAI be completed by a staff member as a part of his or her patient care responsibilities. Another panelist agreed that existing facility personnel should be used to administer the UNAI.

Panel members concurred with the opinion that the use of the UNAI should not place an unnecessary financial burden on facilities. However, several panelists stated that this position should not preclude the hiring of additional discharge planning staff should a facility have



---

insufficient resources to adequately evaluate patients' needs for post-hospital care.

The Panel believed that the recommendation should not require facilities to employ staff solely or specifically for the administration of the UNAI. The Panel agreed that a discipline free approach reflects the Panel's desire to retain institutional flexibility in determining the appropriate assignment of resources to perform the needs assessment function.

Other panelists had concerns regarding the qualifications and training of the assessor. One panelist believed that only registered nurses or social workers should perform the assessment and/or coordinate the input of other health care professionals. Another panelist commented that UNAI assessors should, in addition to the training received for their particular discipline, be required to undergo special training in discharge planning and needs assessment. This panelist did not concur with the Panel's opinion that uniform training in the use of the instrument and supervision by a qualified professional was sufficient to ensure an accurate needs assessment. Discussion then shifted to the merits of a certification process, whereby potential assessors would be required to become certified either in the area of discharge planning/needs assessment or in the use of the UNAI.

The Panel recognized the growing body of knowledge required by professionals to engage in discharge planning and supported the need for improved education for discharge planners. However, there was no consensus to change the

original recommendation. Recommending that the UNAI be completed by qualified and trained personnel without specifying necessary "qualifications" was congruent with the Panel's sense of the community standard of practice. Additionally, it was believed that the lack of a restriction to a particular professional group or discipline would enable facilities to individualize the process according to their unique needs and available resources. The Panel also believed this recommendation was consistent with the legislative intent of the discharge planning requirements found in OBRA '86.

## **C. TRAINING AND UNIFORM USE OF THE INSTRUMENT**

The following three recommendations concern the systems and methods that are necessary to ensure consistent interpretation of items and uniform application of the UNAI:

### **Recommendation #7**

Individuals performing the uniform needs assessment should undergo training in its use. A uniform system for training should be devised to standardize theoretical content and thereby promote consistent application of the instrument.

### **Discussion**

Each individual responsible for coordinating input and completing the assessment, regardless

---

of training received for his or her particular discipline and previous experience in discharge planning, would require training in the use of the UNAI. The individual must understand the purpose and intent of each section of the instrument, as well as the types of responses and level of detail required to complete the UNAI. The assessor must also have an understanding of how to obtain assessment data. This could include acting as a coordinator to solicit information from interdisciplinary team members who may participate directly in the assessment or by gathering information from various sections of the medical record. Furthermore, the individual responsible for coordinating and completing the assessment must understand the role of the needs assessment data in determining the patient's post-hospital care requirements.

In an effort to ensure the reliability and validity of UNAI assessment data, the Panel recommended that a uniform system of training be developed and administered to all UNAI assessors. The Panel believed that HCFA should be responsible for developing training materials and coordinating the training process to ensure uniformity across the country. Lack of a uniform system of training for assessors may result in inconsistent application of the UNAI, thereby defeating the purpose behind implementation of a uniform system of assessment.

The Panel suggested that a core curriculum be developed and instructional methods be used that would ensure that the curriculum is conveyed consistently to assessors and other profes-

sionals who would be responsible for evaluating assessment data. Such instructional methods could include a user's manual, on site training by specially trained (i.e., "Train the Trainer") personnel or use of a videotape to supplement training coordinated by a facility.

One panelist suggested that assessors should not only undergo uniform training but also be certified in the use of the instrument. While there was general consensus that an evaluation of the efficacy of the training process would be needed, there was not support for the development of a certification examination at this time. However, a post-test could be used to evaluate individual learning or an evaluation of the training process could occur as part of a facility's Quality Assurance program.

### **Recommendation #8**

A user's manual should be prepared to accompany the uniform needs assessment instrument that would include the procedure for use and definition statements for the assessment items.

### **Discussion**

As previously discussed in Chapter 4, the Panel wanted the UNAI to be concise and free of unnecessary detail. Wording on the UNAI was limited to specific assessment items and cues necessary to ensure proper use. The Panel proposed that a user's manual be developed to serve as a uniform reference to health care facilities.

---

The Panel intended that the user's manual would supplement information provided in the uniform system of training for assessors.

The Panel believed that a user's manual would allow HCFA to promote consistent application of the UNAI by defining the terminology and describing the process to be used in eliciting assessment information. While it is necessary to make specific instructions available to all assessors, diverting this detail to a user's manual would allow much of the text to be removed from the instrument itself, keeping the UNAI brief and easy to administer.

The Panel had two objectives as it debated the proper balance of information contained on the UNAI and in the user's manual. First, the UNAI collects only the minimum data necessary for an assessment of a patient's post-hospital care needs. An effort was made to streamline the form to keep it as brief and easy to use as possible. It was felt that the size of the form could mislead users into making an unfair assumption regarding time required for completion and administrative burden. Therefore, every effort was made to minimize unnecessary detail.

However, the Panel did feel that a certain amount of detail was necessary in the form of partial cues or definitions to facilitate form completion and decrease the assessor's reliance on the user's manual. Detailed definitions necessary to explain the scope and intent of each item, as well as examples of the type of information that might be elicited, would be contained in the user's manual.

Several Panel members strongly believed that moving cues, definitions, and other supporting information from the instrument to the proposed manual would increase the difficulty of using the UNAI and decrease its administrative feasibility. They believed that UNAI assessors would be required to refer constantly to the proposed manual, and that this would make the assessment process more time consuming than if the instrument were longer and self-sufficient. This viewpoint was not shared by the majority, however.

### **Recommendation #9**

The sources of information for assessment items should be specified in the form of cues on the assessment form and/or in the user's manual.

### **Discussion**

The Panel believed that uniformity of UNAI application could be enhanced if the sources from which information should be elicited were specified either on the instrument and/or in the user's manual. In either case, specifying the recommended source(s) of information would help to standardize the needs assessment process by requiring the assessor to gather information from the same source for each patient.

Several Panel members expressed differing viewpoints. As in the previous recommendation, they believed that shifting "sources of information" to the user's manual would increase the assessor's dependence on the manual.

---

## **D. PROCESS FOR PERFORMING THE ASSESSMENT**

The Panel adopted two recommendations related to the process for performing the assessment. The first recommendation addresses the sources from which information for the assessment may be obtained and the second recommendation addresses the process by which the UNAI would be completed:

### **Recommendation #10**

Sources from which information for the needs assessment may be obtained include the patient's clinical record, direct clinical observation and information reported by the patient, family and other allied health care professionals who have or will be involved in the care of the patient.

### **Discussion**

The Panel sought to specify the possible avenues through which information could be elicited. This was in response to some confusion expressed by the field about where the assessment data would originate. The recommendation also seeks to acknowledge that there are multiple sources from which data may be obtained. One Panel member emphasized the need to ensure that the data is collected in as objective a manner as possible and stated that more than one source may be required to validate the accuracy of the information.

### **Recommendation #11**

The process by which the needs assessment instrument is completed is flexible and may be modified to accommodate the diverse resources and organizational structures of various health care settings. Assessment methods may include assigning an individual sole responsibility for performing the continuity of care assessment or assigning an individual(s) to coordinate interdisciplinary input and be responsible for completion of the form. A number of professionals representing specified clinical disciplines may also be assigned responsibility for completion of distinct sections of the instrument.

### **Discussion**

The Panel introduced this recommendation to clarify the range of options available in completing the instrument. As in the previous recommendation, the Panel sought to address misconceptions that surfaced during the field review and comment period. Many reviewers assumed that responsibility for the assessment would fall solely on an individual discharge planner while others presumed the instrument required multidisciplinary participation. The Panel wished to avoid prescribing the manner in which the assessment should be conducted, although the following recommendation expresses the Panel's preference for an interdisciplinary process.

---

### **Recommendation #12**

Contributions by all appropriate health care professionals should be structured as part of the assessment process.

### **Discussion**

The Panel strongly believed that the needs assessment process should be an interdisciplinary effort and responsibility in all care settings. As noted in chapter 4, numerous disciplines have a unique body of knowledge that may be vital to evaluate a patient's needs for continuing care. While physicians, nurses and social workers have traditionally been responsible for this assessment, input from other professionals, such as physical therapists, occupational therapists, speech therapists, dieticians and respiratory therapists, may be necessary.

While an interdisciplinary team conference may be an optimal method of evaluating a patient's needs, the Panel realized that this is not always realistic, possible or even desired by some facilities. The UNAI was developed to incorporate relevant findings by various disciplines, but the intent of the Panel was not to prescribe the process by which completion of the form should occur.

## **E. TIMING OF THE ASSESSMENT**

The Panel made the following two recommendations regarding the timing of administering the UNAI in the acute care setting:

### **Recommendation #13**

The assessment instrument should be initiated as soon as possible after admission and updated as close as possible to the patient's discharge, as appropriate.

### **Discussion**

The Panel determined that setting a specific time requirement for assessment performance may pose an unnecessary administrative burden for many health care settings. Initially, the Panel considered a motion to require that an initial needs assessment be conducted within 72 hours of admission, and that an updating of the assessment be required not more than 36 hours prior to discharge. After discussion, the Panel concluded that it was impractical to specify an optimal timeframe for completion of the assessment in view of the wide variation in patient length of stay.

The Panel believed that the timing of the assessment should be relative to the patient's actual clinical condition and length of stay; any fixed time requirement would be arbitrary and risk promoting mere paper compliance with the process. Many care settings have limited discharge planning staff resources. Specifying a timeframe for completion of the UNAI might set

an unreasonable and unnecessary expectation that some providers may be unable to meet. Panel members also stated that the instability of patients' conditions in acute care would make it difficult to set any time requirement that was

---

practical. As a compromise, the Panel agreed that the underlying issue would be addressed by recommending that the assessment start as soon after admission as possible and be updated as close to discharge as possible.

The Panel adopted the recommendation unanimously; however, some panelists expressed the opinion that a minimum of two complete assessments (upon admission and updated before discharge) should be required, unless time constraints make this impossible. One panelist stated that two assessments are necessary to establish a baseline from which to measure progress. Assessing the patient at discharge to determine his or her progress since admission may provide the best indication of the patient's potential capacity to benefit from rehabilitative services.

#### **Recommendation #14**

Various sections of the needs assessment instrument should be completed when the patient's status within a given assessment domain is most reflective of the patient's needs for post-discharge care. Some types of information (e.g., sociodemographics) would remain constant and could be assessed immediately after admission or as soon as the information becomes available. Other factors (e.g., functional status) may change as the patient's condition evolves and may need to be evaluated later during the course of care to gain an accurate picture of the patient's capabilities and continuing care requirements.

#### **Discussion**

This recommendation was intended to clarify and compliment the previous recommendation. It attempts to address the dynamic nature of an acute care episode for both the patient and the health care team. Ideally the assessment would begin soon after admission but the Panel recognized that assessment data might be available at different times during the episode of care. For example, demographic information could be collected on admission since it is relatively static in nature. Functional ability, conversely, may be better evaluated as the patient is nearing discharge since his or her condition and capabilities may change considerably during the hospital stay.

#### **F. RESOURCES NECESSARY TO ADMINISTER THE INSTRUMENT**

The Panel made a single recommendation regarding additional resources that may be required by providers to implement a uniform system of needs assessment:

#### **Recommendation #15**

If use of the needs assessment instrument is mandated through regulation, Medicare payment rates should be adjusted to compensate providers for the additional cost of performing the assessment.

---

## **Discussion**

Should a feasibility analysis and field testing results determine that implementation of a uniform system of needs assessment will create additional costs for health care providers, the Panel urged Congress and HCFA to provide adequate compensation for expenses related to performance of the assessment. It was acknowledged by members of the Panel that existing hospital standards and regulations include provisions related to discharge planning. Current requirements, however, provide considerable latitude to the health care provider in defining the scope and content of its needs assessment process. The Panel adopted this recommendation in response to concerns that, in the face of Medicare budget reduction trends, providers could not afford to absorb resource intensive program expansions.

## **G. POPULATION TO WHICH THE INSTRUMENT SHOULD BE ADMINISTERED**

The Panel made one recommendation regarding the population to which the instrument should be administered:

### **Recommendation #16**

The uniform needs assessment instrument should be administered to those patients who require a more extensive discharge planning

evaluation as identified by uniform high risk screening criteria applied to all Medicare patients. The assessment instrument should also be administered to those patients referred by any member of the health care team and, upon request of the patient/family.

## **Discussion**

Given the resources required to complete a structured needs assessment, the Panel believed that the UNAI should be completed only for those patients that warrant a more comprehensive discharge planning evaluation. The Panel assumed that facilities would utilize a system to identify high-risk patients, as required by OBRA '86 (see Chapter 6).

To further ensure that all patients requiring more extensive discharge planning are identified, the Panel also recommended that the UNAI be administered to those patients referred by any member of the health care team for further evaluation. In addition, any patient or patient's family could request a thorough needs assessment via the UNAI.

Discussion of the recommendation resulted in debate over the reliability of screening systems to identify patients requiring an extensive discharge planning evaluation (e.g., administration of the UNAI). Concern about the potential for adverse outcomes for those patients who require an evaluation but fail to be identified by the screening system led the Panel to explore other options. One panelist suggested that all patients

---

should be assessed by the UNAI; another felt that a uniform system for screening should be required as the basis of a uniform system of needs assessment.

Several panelists believed that the UNAI should not be administered to all Medicare patients. In many cases, extensive evaluation is not clinically warranted. In view of the resources required to administer the UNAI and existing shortages of professional personnel, requiring completion of the UNAI for each Medicare beneficiary was viewed as an unnecessary administrative burden that could not be justified from a clinical perspective. Despite the research advantages associated with administering the UNAI to all Medicare patients, several panelists believed that current screening procedures for discharge planning adequately target the population in need of a more extensive discharge planning evaluation.

The panelists disagreed about how to integrate the concept of prescreening for a more extensive discharge planning evaluation with recommendations for the use of the instrument. Some members of the Panel thought that screening criteria should be uniformly defined, believing that it is necessary to establish baseline criteria by which all patients would be screened to assess their need for a more extensive discharge planning evaluation. These panelists believed that uniform screening criteria should be part of the uniform needs assessment process developed by the Panel or that HCFA should specify such criteria as part of the hospital discharge planning

requirements mandated by OBRA '86. However, most Panel members believed that screening criteria and procedures must be facility-specific or designed to meet the needs of each facility's particular case-mix.

The Panel unanimously agreed to recommend that the UNAI be completed for only a subset of Medicare beneficiaries. However, the Panel believed this issue may require further study and requested more information on the effectiveness of current screening practices. Questions were posed regarding the percentage of patients who are identified through screening to require an extensive discharge planning evaluation, both in terms of the national average as well as how this percentage varies according to geographical location or case-mix. Panelists also felt there was a need for research on the number of patients who "slip" through screens (i.e., require a discharge planning evaluation but do not receive it). There was general agreement that evaluation of the adequacy of discharge planning (and the impact of the UNAI on this process) must begin by considering the adequacy of the screening process to identify patients who require a more comprehensive evaluation.

## **H. USE OF INSTRUMENT IN NON-ACUTE CARE SETTINGS**

The Panel adopted two recommendations regarding the use of the instrument in non-acute care settings. The first recommendation addresses use of the instrument in multiple care



---

settings, and the second recommendation addresses the transfer of assessment data to alternate care providers to promote continuity of care:

### **Recommendation #17**

The uniform needs assessment instrument may have applications for use in multiple care settings to identify needs for continuing care. The instrument could be used to periodically evaluate that needs have been accurately identified, as well as to evaluate the continuing care needs at the time of discharge.

### **Discussion**

After much discussion, the Panel determined that its efforts should initially be focused on developing one instrument that would meet the specifications of Congress. The UNAI, although originally developed using an acute care framework for the evaluation of post acute-care needs, is also intended as a tool to assess continuing care needs for patients already receiving some type of post-acute care. Assessment by a post-acute care provider may determine that adjustments in the types of services being provided are necessary to support the patient's changing needs.

After developing a draft UNAI, the Panel discussed the need to develop additional care setting-specific instruments or modules to supplement the draft instrument. The Panel determined that the UNAI contained those elements that were necessary to determine needs for extended care, regardless of the setting (or level of care) in

which the assessment was conducted. The Panel believed that the instrument could be used by any type of provider to evaluate a patient's needs after discharge from that level of care. For example, professionals in a skilled nursing facility or home health care agency could use the UNAI to evaluate continuing care needs prior to formulating the discharge plan.

There are two possible situations that may necessitate the development of modules that are specific to a particular care setting:

- o If Congress were to decide to mandate the use of a uniform needs assessment instrument to determine eligibility for Medicare-covered services, it may be necessary to develop modules containing those specific elements that are required for eligibility determinations (this is discussed in more detail in chapter 7); and
- o Care setting-specific modules may also be needed should Congress decide that the UNAI should be used for purposes other than an assessment of continuing care needs. For example, the UNAI does not contain the level of detail that is needed for care planning (i.e., to assess a patient's specific needs within a care setting.) Providers **such** as nursing facilities and home health care agencies would still need to conduct an **indepth** patient assessment prior to developing a plan of care.

Some panelists believed that the Panel should develop subsets or modules for expanded or modified versions of the UNAI (i.e., for special patient populations, special care settings or alternate care modalities.) Panelists cited

---

populations, settings and special care needs that cannot be covered adequately through one generic assessment instrument. They believed that certain patient populations, such as rehabilitation and psychiatric patients, may have distinct clinical needs that would require a more specialized evaluation. However, the Panel concluded that attempting to satisfy all the unique assessment requirements of every potential UNAI user would reduce the quality and utility of the UNAI. Therefore, the Panel agreed to focus its efforts on designing a single instrument with the broadest application to continuity of care assessment across various types of settings.

### **Recommendation #18**

Assessment data generated from the uniform needs assessment instrument may be used to augment information regarding a patient's needs for continuing care that accompanies the patient when he or she is transferred to another care setting. Such information may contribute to the initial data base used to plan the patient's care by the receiving provider.

### **Discussion**

Using a continuum of care model, the Panel viewed the needs assessment as occurring within a care episode that was but one point in the trajectory of that patient's course of need for extended care. The Panel believed multiple assessments may be necessary over time, as the patient's condition improves or deteriorates,

thereby requiring an alternate level of care. The Panel attempted to promote continuity of care for patients assessed with the UNAI by recommending that the assessment results contribute to the data base used by post-hospital care providers to develop a treatment plan. The Panel believed that the assessment information collected by one provider should be transferred with the patient to the next care setting. Although the information may not be directly useful at all times, the data will augment the receiving facility's assessment and serve as a basis for comparison. By transferring needs assessment information, the acute care facility provides the continuing care provider with a better understanding of the patient's strengths and weaknesses, some of which might not be apparent upon admission.

Several panelists believed that automatic transfer of assessment findings to a new care provider could be prejudicial to the patient. For example, a patient assessed as having a history of mental illness may be denied admission to a nursing facility. In this example, the patient may not currently be affected but will be denied admission because the nursing facility does not have access to mental health services. This type of situation, the panelists argued, is very common and could cause patients to be discriminated against on the basis of outdated information. The Panel sought to minimize this concern by stipulating that the UNAI instruct the assessor to document only those current or recent problems/risk factors that may affect post-discharge care needs.

---

The Panel also recommended that the UNAI become a part of the patient's clinical record, thereby protected by legal safeguards and facility-specific policies to ensure confidentiality and inappropriate release of information. UNAI forms would be maintained on the permanent clinical record and released only with the patient's prior authorization. Such a system could require the beneficiary's written consent before a completed UNAI would be released to a continuing care provider or fiscal intermediary responsible for evaluating medical necessity in determining eligibility for covered services.

## **I. COORDINATING DATA ELEMENTS**

The Panel developed three recommendations regarding the coordination of data elements to minimize duplication of assessment information:

### **Recommendation #19**

Other care setting-specific assessment documents should be a valuable source of information for the uniform needs assessment.

### **Discussion**

The Panel agreed that information required by the UNAI could be collected from other patient records and institution-specific forms. For example, at the time of admission, an assessment is performed by both the nursing staff and the attending physician, with information recorded

on the nursing data base and history and physical respectively. The nursing data base and the physician's history and physical data could supply much of the information needed to perform a needs assessment. The Panel recommended that these and other forms of internal documentation be used, whenever possible, as a source of data for the UNAI.

### **Recommendation #20**

Should a uniform needs assessment process be implemented within an institution or be mandated through regulation, efforts should be made to minimize duplication of required information. However, in cases where the purposes of the assessments differ, this may not be possible.

### **Discussion**

The Panel strongly agreed that implementation of a uniform system of needs assessment should not cause discharge planners and/or other staff members to unnecessarily duplicate assessment efforts or require the transfer of information from one form to another. Facilities choosing to use the UNAI should evaluate the UNAI in relation to the specific types of assessment and/or documentation responsibilities of staff members at all levels. Efforts should be made to minimize unnecessary duplication of information by merging and/or streamlining forms that serve essentially the same purpose.

However, in some instances, it may not be possible to standardize terminology or eliminate

---

duplication of information. The nature and level of detail required in an assessment instrument is determined by the purpose of the assessment. Therefore, assessments generated for divergent purposes may be impossible to coordinate or merge. In addition, adoption of a uniform system of needs assessment would not eliminate the provider's responsibility to meet State requirements. Some states may require completion of specific types of assessments. A prime example of this would be found in states that have developed case-mix programs to reimburse long-term care providers based on the amount of resources required by patients.

### **Recommendation #21**

Should its use be mandated, the UNAI should be studied in relation to other existing Federal forms. Efforts should be directed towards consolidation and standardization of data elements, with the objective of reducing overlap and duplication.

### **Discussion**

Should Congress decide to mandate use of the UNAI, there should be a focused initiative undertaken to ensure that the needs assessment instrument is consistent with other existing Federal forms and Medicare/Medicaid program requirements. This should include an attempt to standardize terminology and measurement scales where appropriate. Possible areas for further

exploration that were raised during the Panel's deliberations include the:

- o Minimum Data Set for Nursing Facility Resident Assessment, OBRA 1987;
- o Functional Assessment Measures developed for use in Medicare certification surveys of home health agencies, OBRA 1987;
- o HCFA Mental Retardation/Mental Illness Preadmission Screening and Annual Resident Review (PASARR), OBRA 1987;
- o HCFA forms 485, 486, 487 and 488 used to document Medicare eligibility for home health services, and
- o Medicare discharge planning regulations for hospitals, OBRA 1986.

## **J. MECHANISMS TO ENSURE ACCOUNTABILITY FOR PERFORMANCE AND RELIABILITY OF THE ASSESSMENT**

The Panel recommended a dual approach to ensuring accountability for the performance of the needs assessment process. The provider would have primary responsibility with additional safeguards established through regulatory means:

### **Recommendation #22**

Monitoring the accuracy of assessment data and adequacy of the assessment process should

---

occur as part of the institution's Quality Assurance program.

### **Discussion**

The Panel believed that each facility should be responsible for the accuracy of needs assessments and the adequacy of the assessment process. Each facility would be required to designate the person(s) responsible for coordinating completion of the UNAI and/or overseeing the needs assessment process. Each facility would also be required to designate responsibility for ensuring the reliability of assessment data.

### **Recommendation #23**

Assessment data collected on the uniform needs assessment instrument could be used by the PROs to monitor the adequacy and appropriateness of the discharge planning process.

### **Discussion**

The Panel believed that some type of regulatory means would be required to validate the provider's ability to provide an accurate and adequate needs assessment. The Panel suggested that HCFA consider use of the Peer Review Organizations (PROs) to provide an external and unbiased audit of the assessment process.

Involving the PROs in the review of UNAI data would also result in a secondary gain. The PRO reviewer could use the UNAI to monitor the adequacy and appropriateness of the discharge

planning process. The PROs currently use a generic quality screen to assess the adequacy of discharge planning. However, the Panel found that this process has been criticized in that there are few standards delineating necessary documentation and there is much variation in recordkeeping across facilities. Given that much rests on the subjective judgment of the nurse reviewer, the UNAI could play an important role in increasing the objectivity of this review (see Chapter 6 for a more detailed discussion).

The development of an external process to ensure that the assessment is being conducted by a qualified and trained individual may also be necessary.

## **K. TESTING AND EVALUATION**

The Panel adopted three recommendations regarding testing and evaluation of the UNAI. These recommendations center around established phases of the instrument development process:

### **Recommendation #24**

The draft instrument should be circulated for review by clinical experts in discharge planning and post-hospital care. Comments should be evaluated to determine the need to modify the draft instrument in order to enhance the content validity and administrative feasibility of using the instrument in various care settings.

---

## **Discussion**

The first step in evaluating the UNAI is the establishment of content validity. Content validity is determined by consulting experts in the content area to analyze the items within the instrument, with the goal of concurrence by the field on the appropriate content for the instrument.

The Panel desired to complete this phase prior to completing their recommendations to the Secretary. A period of review and comment regarding a draft version of the UNAI and recommendations for its use was conducted by HCFA on behalf of the Panel. Comments were solicited from interested associations and organizations, a stratified random sample of providers including hospitals, skilled nursing facilities and home health agencies, and individuals with varied backgrounds and expertise in needs assessment. Comments from the field were considered by the Panel during its final meeting; they provided feedback and specific suggestions for the Panel to consider in preparing their final recommendations regarding the needs assessment instrument. A report summarizing the comments received from the field is found in Appendix D.

## **Recommendation #25**

The uniform needs assessment instrument should then be field tested in a representative sample of hospitals, home care agencies, and nursing facilities of a variety of sizes, types, and locations, to establish criterion and construct

validity as well as reliability and administrative feasibility.

## **Discussion**

As the second phase in the evaluation process, the UNAI should be field tested in a pilot study. The Panel requested that a plan for field testing be developed that would stratify sites according to geographical location, size and other characteristics; this would ensure that results were as representative of the various facilities that might use the UNAI as possible.

The reliability of the instrument would be established during this phase of testing, with results evaluated to determine whether the tool performs consistently across raters and settings. The study of reliability could be broken out to substantiate the Panel's recommendations regarding the use of the instrument. The performance of particular disciplines (i.e., social workers, nurses or other qualified personnel) could be studied to ensure that all types of assessors have an acceptable level of reliability. The reliability of assessment data generated by staff members in various care settings (i.e., hospitals, nursing facilities or home health agencies) should also be evaluated to confirm the appropriateness of use of the tool across care settings. Process considerations could also be studied to determine whether the UNAI performs best as a compilation of available data or requires an additional assessment.

---

Criterion validity deals with the instrument's utility as a predictor of subsequent needs for care. An evaluation of the UNAI's criterion validity would address whether the UNAI is able to fulfill its stated purpose of identifying needs for post-hospital and other types of extended care. A comparison of UNAI data obtained pre- and post-discharge could be used to determine whether the instrument consistently predicts continuing care needs. A sample of patients could be followed longitudinally to determine whether the post-hospital options for care that were identified by the UNAI were predictive and met the patient's actual needs after discharge.

In addition, field testing is necessary to determine the UNAI's administrative feasibility. Factors such as the amount of time and level of resources required to perform the assessment as well as the type and amount of "uniform" training required to provide an adequate orientation for assessors would be part of the evaluation of administrative feasibility. Issues related to the automation of needs assessment data could also be studied during a pilot, with a focus on the feasibility of automating data collection.

The Panel strongly believed that the results of field testing should be evaluated and necessary modifications made to the UNAI and/or the proposed system for its use before the UNAI is considered for uniform use.

### **Recommendation #26**

Should a uniform needs assessment instrument be mandated, a long term evaluation of the

validity of the assessment process should be considered. This should include a study of the impact of the assessment process on the problem of patients being discharged without their needs for continuing care being addressed.

### **Discussion**

A long term evaluation of a uniform system for needs assessment should focus on the capacity of the system to identify high-risk patients and accurately assess their needs for post-discharge care. The Panel believed that the ultimate appraisal of the UNAI's value should be determined by its effect on discharge planning outcomes. Indicators of quality of care and quality of life (i.e., rehospitalization rates, ability to remain in the least restrictive setting possible and the maintenance of functional abilities) could be used to evaluate the impact of the UNAI on facilitating quality continuing care.

A long term evaluation could also examine the capacity of current community health and social services to meet identified patient/family continuing care needs and to identify quality problems resulting from limited access to post-hospital services. The UNAI could be used as a baseline measure to assess whether patients actually received "necessary" services.

The effect of the UNAI in facilitating continuity of care across various types of care settings should also be studied. The role of the UNAI in conveying useful information to continuing care providers could be evaluated from the

---

perspective of whether the UNAI is used by continuing care providers to supplement their assessment for care planning purposes.

A final area that requires long term evaluation is that of the relationship of UNAI recommendations/options for continuing care to the actual discharge decision. Further study is needed to determine whether it is possible to cluster assessment data to facilitate the discharge plan decision. This could result in the development of an algorithm or decision-tree that could provide an additional safeguard in the discharge planning process. A separate but related issue concerns the relationship between a patient's "needs" for care and/or services identified by the UNAI and the fiscal intermediary's determination of eligibility for post-hospital services.

The following chapter describes several other issues that the Panel considered during their deliberations. These issues include liability concerns associated with the UNAI and the potential use of the UNAI for quality assurance and generation of a national data base for research and policy decisions.



---

## CHAPTER 6:     ADDITIONAL   CONSIDERATIONS

The Panel designed the UNAI as a tool for assessing a patient's needs for post-hospital care in a uniform manner in various settings. It could facilitate communication regarding the care needs of patients across the health care continuum. However, should use of the UNAI become mandated through regulation, it could have ramifications beyond the clinical purpose for which it was originally designed. Not only would there be consistency in the items and language used to assess patients, but a new standard for clinical assessment would be established.

For example, as will be discussed in this chapter, the use of the UNAI may affect the liability of providers as well as have implications for quality assurance. In addition, needs assessment data could be compiled for analysis, serving as the basis for research and policy decisions. Government agencies or third party payers could also utilize needs assessment data to determine a patient's eligibility for covered post-hospital services.

While primarily concerned with the instrument development process, the Panel recognized that part of their charge was to consider the other uses to which the UNAI may be put, while designing the instrument and offering recommendations for its implementation.

### A.   LIABILITY   CONCERNS       ASSOCIATED WITH THE UNAI

Some members of the Panel were concerned that the UNAI might increase or alter the liability of health care providers for poor outcomes after discharge. The Panel heard an overview of legal standards governing the discharge planning process and received counsel on liability concerns associated with the uniform needs assessment initiative.<sup>1</sup>

Concern about liability issues does not mean that the behavior of professional staff members involved in needs assessment is motivated solely to minimize their exposure to liability. Rather, panelists acknowledged that ethical, professional and other non-binding standards of practice guide those professionals responsible for assessing a patient's needs for continuing care.

#### **Legal duties related to the needs assessment process**

Health care institutions and their employees have legal duties to their patients, which imply specific responsibilities for the professional staff involved in the needs assessment and discharge planning process. A breach of these duties, resulting in injury or death, may result in litigation against the institution and/or its employees. General principles that define the legal relationship and responsibilities of the patient, institution

---

<sup>1</sup> Unless otherwise indicated, much of the following discussion is abstracted from a December 8, 1988, presen-

tation made to the Panel by Suzanne Mitchell, J.D., an expert on legal issues related to discharge planning.

---

and institution's employees in the needs assessment process are as follows:

- o Patient right of self-determination. A competent adult patient (or the authorized surrogate decision-maker if the patient lacks sufficient decision-making capacity) has a right to make informed choices and decisions about medical care, treatment and post-hospital placement (American Hospital Association Memo-randum (AHA Memo), 1987). Professional staff should advise the patient regarding his post-hospital needs, identify available options, and take reasonable steps to facilitate appropriate post-hospital placement. However, the competent patient is the final decision-maker and is thus ultimately responsible for decisions about post-hospital care. Depending upon the circumstances, the discharge planner who attempts to override the wishes of a competent patient or appropriate surrogate may expose himself or herself and/or the institution to liability.
- o Provider duty to patient. In order to establish provider liability in a negligence (malpractice) case, a plaintiff must show that the hospital or discharge planner owed the patient a "duty," that the duty was breached, and that the breach proximately caused an identifiable injury to the patient. The actions of the provider are judged according to standards of care that define what can be expected from a "reasonably prudent" practitioner; these standards emanate from decided court cases, Federal and State laws and regulations, standards of accrediting agencies such as the Joint Commission on Accreditation of Healthcare Organizations, professional licensure require-

ments, institutional policies and procedures, and so on.

The fiduciary and contractual duty the provider owes the patient has been generally stated: "to exercise reasonable care in treatment, to protect the patient from reasonably foreseeable harm and to provide medically necessary care" (AHA Memo, 1987, p. 25).

The duty owed the patient in formulating a discharge plan lies not in making the decision for aftercare arrangements but rather providing information to the patient or surrogate about appropriate post-hospital options, supporting the patient or the patient's surrogate in the decision-making process, and taking reasonable steps to implement an appropriate decision. The professional staff member's responsibility in advising and supporting the patient includes:

- assessing the patient's medical readiness for discharge;
- identifying and assessing the social service network available to the patient after discharge, and taking "reasonable steps" to arrange for those resources to be made available to the patient, and
- informing the patient of any post-hospital services he or she needs, the efforts that hospital personnel have made to meet those needs, the barriers (if any) that exist in meeting those needs, the reasonably foreseeable outcomes of a discharge and any alternatives to the discharge plan that exist (AHA Memo, 1987, p. 7).<sup>2</sup>

---

<sup>2</sup>Further information can be found in the AHA memorandum, Discharging Hospital Patients, and additional

references listed in the bibliography of this report.

---

### **Implications of a uniform system for needs assessment**

If the discharge planning process is viewed as a continuum, liability concerns related to the discharge planning process can be raised at various points. Concerns can generally be summarized under the categories of “when to discharge the patient” and “how to discharge the patient.” In terms of the legal duties of providers, these categories encompass a clinical standard that reasonable steps have been taken to identify the patient’s post-hospital needs, to anticipate what is reasonably foreseeable as a result of those needs not being met and to take reasonable steps to match the needs of the patient with the services that are available in the community. This component of discharge planning is of relevance to the uniform needs assessment initiative.

### **Effect of the UNAI on the liability of institutions and professional staff**

Regardless of whether the UNAI becomes mandated through regulation, there has always been an obligation on the part of hospitals and professional staff to conduct a needs assessment for their patients. This is a professional standard of care as well as a requirement of hospitals participating in the Medicare program. It is reflected in the standards of the Joint Commission on Accreditation of Healthcare Organizations as well as the Medicare Conditions of Participation.

Should use of the UNAI become required, courts may come to view the instrument as defining a national standard for the needs assessment phase of the discharge planning process. While standards related to discharge planning have been promulgated by professional associations at the national level, informal standards regarding the components of discharge planning have varied considerably across the country and even from facility to facility in the same geographical region.

Limitations in available staff resources and differences in access to various types of post-hospital services may create differences in what reasonably can be accomplished by discharge planners. Therefore, standards for the discharge planning process must be based on what is reasonably achievable, and should not be unrealistic in setting expectations beyond what is legitimately possible.

To the extent that the UNAI merely reflects on paper what current standards for the needs assessment process are, the instrument would have relatively little effect on the liability of institutions and clinicians. However, if the instrument encompasses a broader or more comprehensive range of items than are currently being assessed by most providers, the standard of care could be raised if the instrument becomes mandated. For this reason, the Panel developed the instrument so that the standard set for assessment did not exceed what was achievable and could be accomplished by reasonable providers. The Panel was particularly cognizant of the varia-

---

tions among' providers in terms of the resources and organizational structures they had available to implement such a system, as well as the practical difficulties faced by discharge planners in many institutions, particularly small, inner city or rural hospitals.

Consequently, an attempt was made to balance the divergent goals of developing a standard of excellence and a standard that was achievable. Members of the public and Panel representing particular disciplines or special interest groups advocated the inclusion of some items that would have allowed a more in-depth level of assessment; these items were not included in the Panel's final recommendations, however. The instrument represents the Panel's calculation of the minimum data necessary to assess needs for continuing care. The UNAI should not, therefore, set an unrealistic standard of care for the needs assessment process.

Because the UNAI represents the minimal level of assessment necessary to assess needs for extended care services adequately, many providers may choose to supplement the UNAI with additional tools in order to meet a more comprehensive level of assessment that may be required by institutional policies and procedures, State and local law, or standards of private accrediting bodies.

The Panel also recommended that the UNAI have no direct effect on standards governing any other phase of the discharge planning process. The instrument should not in any way represent a minimum standard for the entire discharge planning process.

### **Role of the UNAI as objective evidence of the needs assessment process**

The UNAI is a formal record of the needs assessment process. Should providers be required to complete the UNAI for those patients requiring an evaluation of their needs for continuing care, the UNAI may become a record of a process that had previously not been formally documented by some providers. Professional staff may have assessed patient information similar to that contained on the UNAI prior to formulating a discharge plan but not have documented that information. Providers may be reluctant to document their assessment, believing that demonstrating knowledge of factors such as lack of social support or an unsafe environment could increase their liability and provide concrete evidence of negligence should the discharge arrangements result in harm to the patient.

To the extent that the UNAI would formalize and provide more objective evidence of the needs assessment process, a standardized needs assessment form may make it easier to prove a breach of the standard of care. However, a lack of formal documentation would not exonerate the professional staff member. Regardless of whether a standardized form is adopted, the discharge planner remains responsible for assessing and planning for the needs of the patient. Conversely, it is possible that a standardized needs assessment process may even reduce the liability of providers. Professional staff members using the UNAI would have a structured process available by

---

which to document fulfillment of their needs assessment responsibilities, thereby eliminating speculation regarding what the assessment should include and how it should be documented.

Legal precedent suggests that standardized documentation alone probably will not add to a provider's exposure to liability or protect a provider from claims of negligence. Courts determine the adequacy of the needs assessment using a variety of fact-finding processes, ranging from review of clinical records to evaluating the statements made by a patient and family. As such, a standardized needs assessment form would be one piece of evidence among many and may not substantially influence the court's decision regarding the adequacy of the needs assessment.

### **Effect of signature on the liability of the needs assessor**

Some panelists were concerned that by requiring the assessor to sign the UNAI, the assessor would assume responsibility for the discharge planning process and incur liability for any decisions regarding aftercare arrangements made on behalf of the patient. However, regardless of whether the assessor's signature appears on the UNAI, the designated discharge planner is responsible for performing a needs assessment. The attorney who advised the Panel viewed the

assessor's signature on the UNAI as largely irrelevant; it would simply corroborate that the needs assessment process had taken place.

### **Assignment of liability among professional staff**

Panel members also questioned whether in signing the UNAI, the assessor would assume sole responsibility for the outcome of the needs assessment process. Signature would not increase the assessor's risk of liability nor shift liability from other health care professionals involved in a patient's care to the UNAI assessor.

The professional responsibility of each member of the discharge planning team is defined by law and custom, in the forms of legal precedent, Joint Commission standards and the Medicare Conditions of Participation. Although the exact nature and distribution of this liability have varied according to court and circumstance,<sup>3</sup> it is clear that no paper form or standardization efforts can shift or decrease health care providers' essential responsibilities regarding the needs assessment as part of the discharge planning process. Overall, discharge planning remains the responsibility of the facility, and discharge decisions the responsibility of the physician.<sup>4</sup> The physician is accountable for the discharge plan.

---

<sup>3</sup> Observers have noted a recent trend to identify all health professionals concerned in the patient's care in malpractice suits. In the area of discharge planning, each health care discipline that interacts with the patient may be held liable (Arcidiacono, 1988).

<sup>4</sup> For example, see *Wickline v. the State of California*, in which the U.S. Court of Appeals ruled that decisions regarding how and when to discharge the patient are the responsibility of the attending physician (Arcidiacono, 1988).

---

Physician accountability for continuing care was provided for on the UNAI in an item requiring the physician's name and phone number. While not a recommendation at present, should the UNAI be used to determine Medicare eligibility for post-hospital services, a physician's signature attesting to the medical necessity and appropriateness of such services may be required.

Panelists also debated whether requiring the signature of all those participating in the needs assessment on the UNAI might make each assessor more individually accountable. Some panelists believed that it might be possible to hide one staff member's personal breach of responsibility behind a team's shared accountability for a patient. The Panel believed that having each person sign the form would be cumbersome, time-consuming and confusing from a practical standpoint. Given that it is possible for discharge planning teams to share responsibility in many different ways, all of which are consonant with good practice, the Panel decided it was not necessary to require each team member to document his or her participation.

Additionally, the patient's own responsibility for poor discharge outcomes cannot be transferred to any member of the discharge planning team. Unless a provider is found liable for professional negligence or abandonment, the patient is accountable for the consequences of the decisions that he or she makes regarding post-hospital care.

### **Effect of the UNAI on liability when needs are identified but not met**

Under the Prospective Payment System (PPS), hospitals have a financial incentive to discharge patients in as timely a manner as possible. While PPS has resulted in decreased lengths of stay overall, hospitals retain the duty to provide all care that is medically necessary. However, the provider's liability is not all-inclusive. The provider cannot be held accountable for ensuring that the ideal or maximal post-hospital arrangements are in place prior to discharge or for guaranteeing the quality of post-hospital services (AHA Memo, 1987).

The Panel questioned whether liability would be increased for the institution if the needs assessment instrument indicated the patient had certain needs that were not able to be met due to a lack of resources in the community or the family. The attorney who addressed the Panel indicated that the hospital would be no more responsible for the patient's post-hospital care needs as a result of the UNAI than it is currently. The hospital would still be, as it has always been, responsible only for taking reasonable steps to meet the patient's reasonably foreseeable post-hospital needs. The UNAI could be viewed by the courts simply as a tool used to facilitate performance of the needs assessment portion of the discharge planning process and not a statement that because needs have been identified, the hospital is responsible for meeting them.

The Panel also deliberated issues surrounding the provider's responsibility to assess fore-

---

seeable risks if identified patient needs are not met. The Panel realized that the more needs for care that are identified by the UNAI, the more documentation there would need to be to reflect how these needs can be met and what the foreseeable risks are if the needs cannot be met. To the extent that the UNAI would formalize and provide more objective evidence of the needs assessment process, the UNAI may make it easier to prove a breach of this standard of care.

### **Effect of patient attestation on the liability of providers**

The issue of patient attestation to the needs assessment process was discussed in terms of what the patient's signature would mean from a legal perspective. Signature could be used to convey that the patient had participated in the needs assessment process, agreed with the information on the UNAI or agreed with the plan recommended to him by the discharge planning team. Patient attestation could also be used to document that the discharge planning professional had fully disclosed the patient's needs for continuing care and options that were available to him. However, it is possible that patients could misconstrue the UNAI and attestation process as acknowledgement of the hospital's willingness to either arrange for, or pay for, necessary post-hospital services.

The attorney who addressed the Panel believed that patient attestation was one of several methods that could be used to document the

patient's/surrogate's involvement in the needs assessment process. However, she expressed reservations about the administrative feasibility of having the patient sign the UNAI and how this process might be perceived by the patient. From a legal perspective, the signature of the patient would not protect the provider from liability if the proper care (i.e., an adequate needs assessment) was not rendered. Nor was a signature necessary if the needs assessment process was documented within the clinical record. While the Panel chose to compromise on this issue by recommending that a separate form be used for patient attestation, the attorney recommended that the professional staff member also document interactions with the patient and family within the clinical record (see Chapter 4 for a more complete discussion).

### **Advisory Panel conclusions**

The Panel concluded that implementation of a uniform system for needs assessment would not have a significant effect on the liability of providers or professional staff. In some cases, it is possible that use of the UNAI may even help reduce liability for claims of negligence by providing a standardized process by which to document assessment of all factors necessary to determine continuing care requirements and resources that are available to support the patient.

---

## **B. USE OF THE UNAI FOR QUALITY ASSURANCE**

Quality assurance mechanisms to ensure the quality of care provided to beneficiaries have been integrated into the Medicare program since its inception. As the Prospective Payment System changed the health care delivery system by decreasing lengths of stay in acute care settings and increasing utilization of post-hospital services, Congress recognized the need to focus quality assurance efforts on evaluating transitional and post-acute care. The Medicare Quality Protection Act of 1986 included a number of provisions related to discharge planning and post-acute care review.

In terms of quality assurance, the uniform needs assessment initiative can be viewed as both a clinical standard of assessment as well as a means to facilitate the review of care provided to beneficiaries. The two primary mechanisms used to ensure the quality of care provided to Medicare/Medicaid beneficiaries are the survey and certification process and Peer Review Organization (PRO) review. The following discussion elaborates on how the UNAI could be integrated into Federal quality assurance efforts.

### **SURVEY AND CERTIFICATION**

Facilities that choose to participate in the Medicare and Medicaid programs must comply with minimum health and safety standards.

### **Requirements for hospitals**

Section 1865 of the Social Security Act allows hospitals to demonstrate compliance with health and safety standards through one of two mechanisms. Hospitals may be certified under the Medicare Conditions of Participation, or be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA). Accredited hospitals are currently “deemed” to meet all the health and safety requirements of the Medicare Conditions of Participation, except for utilization review.

HCFA develops regulations, policies and procedures that delineate the standards and process by which non-accredited facilities are surveyed and certified to receive Medicare and/or Medicaid reimbursement. Program specific changes are made on an ongoing basis through the Federal rule-making process.

Current Conditions of Participation require hospitals to have an “effective, ongoing discharge planning program that facilitates the provision of followup care” (42 CFR 482.2 1). However, the 1986 Omnibus Budget Reconciliation Act (OBRA ‘86) directed that discharge planning become a distinct Condition of Participation for hospitals and added a number of specific requirements to govern the discharge planning process. OBRA ‘86 stipulated that hospitals must:

- o identify, at an early stage of hospitalization, those Medicare patients who are likely to suffer adverse health consequences if dis-



---

charged without adequate discharge planning;

- o provide a discharge planning evaluation for such patients and for other patients upon request of the patient or his or her representative or physician, and
- o such an evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services (OBRA, Section 9305(c), October 17, 1986).

Final regulations requiring discharge planning as a distinct Condition of Participation for hospitals have not yet been promulgated by HCFA. While the above requirements will apply to certified hospitals, the JCAHO and AOA must have comparable requirements in order for accredited hospitals to be "deemed" to meet this new Condition of Participation. HCFA will announce in the Final Rule requiring discharge planning as a Condition of Participation whether JCAHO and AOA accredited hospitals are deemed to meet the new Condition of Participation.

A Notice of Proposed Rule-Making (NPRM) outlining proposed discharge planning requirements was published by HCFA on June 16, 1988. The NPRM stated that additional discharge planning standards may be added after an evaluation of the effectiveness of the above requirements. The NPRM also alluded to the work of the Panel and stated that any requirements related to needs assessment instruments were deferred (Federal Register, p. 22508). HCFA's rationale was that a decision regarding mandating the use of the

needs assessment instrument should be made only after the instrument was thoroughly tested.

The Panel recommended that the needs assessment instrument be administered to those patients who require a more extensive discharge planning evaluation. Such patients would be identified through a system utilizing screening criteria to identify "high-risk" patients; all Medicare patients would be screened. This interpretation is consistent with the intent of the requirement regarding "discharge planning evaluation" proposed in the NPRM. If testing validates the UNAI, it is possible that its use could be required as a Condition of Participation for hospitals, thereby setting forth specific structure and process standards regarding the discharge planning evaluation.

### **Requirements for home health agencies**

In order to receive Medicare and/or Medicaid reimbursement, home health agencies and nursing facilities must be approved under their respective program's Medicare Conditions of Participation.

Revised Conditions of Participation for Home Health Agencies were published as an Interim Final Rule on August 14, 1989, to implement various provisions contained in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). Several regulations indirectly speak to the home health agency's responsibility to perform an ongoing assessment of the patient's needs for continuing care.

---

A new Condition, Patient Rights, stipulates that patients be informed in writing by the home health agency about their care in advance of initiation of treatment. The Committee Report that accompanied OBRA '87 reflected the Committee's intent that the information provided to the beneficiary include, in part, a description of services to be provided and a discussion of alternative options that comply with the physician's plan of care but may better meet the specific needs of the individual (Report of the Committee on the Budget, 1987).

In addition, home health agencies are required to inform patients of recommended changes in their plan of care before the changes are made. The new regulation also permits patients to participate in planning changes in their care or treatment. These general requirements can be interpreted to mean that home health agencies are required to discuss and plan for continuing care needs with the patient or the patient's surrogate prior to the patient's discharge from home health care (Federal Register, August 14, 1989, pp. 33354-33373). The home health agency is also required to complete a discharge summary as part of each patient's clinical record.

OBRA '87 also contained a directive to develop an outcome-oriented survey process for home health agencies. The process is to incorporate the use of a functionally based assessment instrument(s) by surveyors to evaluate the quality of care provided to beneficiaries (see Chapter 3 for a more complete discussion) (Compilation of the Social Security Laws, section 1891).

### **Requirements for long term care facilities**

HCFA published revised Requirements for Long Term Care Facilities as a Final Rule with Request for Comments on February 2, 1989. As part of the requirements associated with OBRA '87's nursing home reform package, nursing facilities must conduct an initial and periodic assessment of each resident's functional capacity that includes the resident's potential for discharge (see Chapter 3 for a more complete discussion). The assessment, which includes measures of the resident's capability to perform daily life functions, must be used by nursing facilities in evaluating and revising a resident's plan of care (Federal Register, February 2, 1989, p. 5364). By specifying the inclusion of discharge potential in the resident assessment requirement, OBRA '87 called for an ongoing evaluation of the patient's status not only for the purpose of ensuring the appropriateness of the nursing facility's plan of care but also the appropriateness of continued stay in the nursing facility.

Ongoing assessment of the resident's discharge potential is important for several reasons. Efforts to promote quality of care and quality of life strive to ensure the patient receives care in the least restrictive environment possible.

Additionally, placement in a nursing home is generally no longer viewed as a final place of residence, but rather as part of the continuum of care (O'Hare, 1988). The average length of unaggregated stays for nursing facility residents is thirteen months, with a median of three months

---

(Spence & Wiener, 1990). Length of stay typically varies according to a bimodal distribution, with residents tending to be classified as “long” or “short-term.”

Prior to the implementation of PPS, needs for other than chronic, supportive care were often resolved prior to discharge from the acute care setting. However, the case-mix of many nursing facilities has changed to include an increased percentage of patients that require a higher level of care than can be provided in the community for a short period of time. For these patients, the goal of nursing home care is rehabilitation and discharge from the facility (Institute of Medicine, 1986).

In any event, assessment of discharge potential is a critical component of a holistic approach to the ongoing assessment of a resident’s needs for care. Most patients are admitted to nursing facilities because of care needs related to functional disabilities that extend beyond the level of support that can be provided by the family or community (Libow & Starer, 1989). However, it is possible that the resident’s status will change during the course of care in the nursing facility. A change in the ratio of the resident’s care needs to available social supports may result in community-based alternatives for care.

Many of the items in the UNAI could be utilized in a nursing facility’s assessment of discharge potential and the identification of viable options to institutional care. Factors such as functional capability and nursing and other care requirements are critical determinants of the type

of post-hospital care needed by patients. Similarly, the nursing facility would need to assess factors such as the presence of family and community supports and the availability of non-institutional living arrangements to determine if there were alternative options for care.

### **Advisory Panel conclusions**

While discharge planning has traditionally occurred primarily in hospitals, recognition of its importance has shifted to non-acute care settings. Recent legislation and regulations make it clear that providers of post-hospital care will become increasingly responsible for evaluating and planning for patients’ continuing care needs prior to discharge, regardless of the setting.

Should use of the UNAI be mandated by regulation, it is probable that implementation would begin in hospitals. However, it is clear from the enabling legislation that Congress intended that the UNAI be developed so that it could also be used by nursing facilities, home health agencies and other types of providers of services to Medicare patients. Such a requirement would not only allow for consistency in patient assessment across care settings but also ensure that patients’ needs for continuing care were addressed prior to discharge from each setting.

---

## PEER REVIEW ORGANIZATION (PRO) REVIEW

As directed by HCFA, PROs review Medicare-covered health care services to determine that the services provided to beneficiaries are reasonable, medically necessary, furnished at the appropriate level of care and meet professional standards. Safeguards developed to ensure quality of care under PPS have included a mandate for PRO review of the adequacy of hospital discharge planning for several years (HCFA Second Scope of Work delineating PRO review functions, 1986-1988 contract cycle; HCFA Third Scope of Work delineating PRO review functions, 1988-1991 contract cycle).

Review is generally conducted on a retrospective basis using generic criteria to detect premature discharges (Berkman, 1988). Generic screens are used by nurse reviewers to identify possible quality problems. Questionable cases are analyzed individually by physician reviewers who are engaged in active practice in the State. The physician reviewers draw upon their education, experience and judgment. If the physician reviewer believes the case to be aberrant, the attending physician and provider are given an opportunity to discuss the case. Then, a PRO physician makes the final determination (i.e., to deny for misutilization or to confirm a quality problem). The following discussion focuses on the generic screens used by the PROs to review the adequacy of the needs assessment and discharge planning process.

## Hospital review

HCFA's generic quality screen for the adequacy of hospital discharge planning is defined as a lack of "documentation of discharge planning or appropriate follow-up care with consideration of physical, emotional and mental status needs at time of discharge." Explanatory notes that guide the review of documentation indicate that the discharge plan must be timely and developed to meet the needs of the patient at the time of discharge. The following elements of a discharge plan must be addressed:

- o A needs assessment;
- o Development of plan, and
- o Initiation of appropriate arrangements and obtaining appropriate resources to ensure smooth transition to post-hospital level of care.

A screen failure occurs when a discharge plan is not documented. A confirmed quality problem is defined as the "presence of patient needs, which were not met" (HCFA Hospital Inpatient Generic Quality Screens, HCFA Third Scope of Work delineating PRO review functions, 1988-1991 contract cycle).

In practice, however, the Panel found that the discharge planning review has been criticized for its subjectivity. The PRO reviewer uses a variety of methods, including review of progress notes and facility-specific flowsheets, to determine the presence of the above elements of the discharge

---

planning process. In a presentation to the Panel, Kenneth Kahn, M.D., Chairman of the American Medical Peer Review Association's (AMPRA) Continuing Care Committee, expressed his opinion that there is potential for inconsistencies in determinations regarding the adequacy of discharge planning; he supported the use of the UNAI in various aspects of PRO review. While the Continuing Care Committee has issued Guidelines for PRO Discharge Planning Review, Dr. Kahn felt the lack of clear structure and process standards detracted from the reviewer's ability to judge the adequacy of discharge planning in an objective manner (K. Kahn, Panel presentation, December 8, 1988).

### **Skilled nursing facility (SNF) review**

While PRO review initially focused on the adequacy of discharge planning in hospitals, the scope of review has expanded to providers of post-acute care. Generic quality screens for skilled nursing facilities direct the PRO reviewer to:

- o Compare the hospital discharge summary with the SNF admission assessment to determine appropriateness of discharge to SNF and appropriateness of admission to and continued stay in that SNF; and
- o If appropriate, determine that relevant disciplines (occupational therapy, physical therapy, speech therapy, social service, physician, nursing and dietary) were addressed by the admission assessment, plan of care, ongoing evaluation and discharge plan.

Explanatory notes indicate that "documentation must be present which addresses the unique needs, circumstances, and plan for each patient individually with modification of plan as condition indicates" (HCFA Skilled Nursing Facility Generic Quality Screens, HCFA Third Scope of Work delineating PRO review functions, 1988-1991 contract cycle).

### **Home health agency review**

The generic quality screen used by the PROs to review home health care specifies that care should include:

- o Intake evaluation that assesses functional limits and caregiver support(s);
- o Appropriate and timely intervention for significant change in social support system;
- o Assessment and implementation of a plan to address restorative needs by specialty therapies;
- o Coordination of services and continual reassessment of patient's needs by nursing staff, with referrals to other disciplines as necessary;
- o Responsibility for termination of care only when services are no longer required (to identify the presence of premature discharge from the home health agency), and
- o Documented plan for appropriate follow-up care and discharge summary to physician(s) of record.

---

Based on the rationale that discharge planning is appropriate for all patients, the screen instructs the reviewer that documentation must be present that addresses the unique needs, circumstances and plan for each patient individually (HCFA Home Health Agency Generic Screens, HCFA Third Scope of Work delineating PRO review functions, 1988- 1991 contract cycle).

### **Advisory Panel conclusion8**

If providers are required by regulation to use the UNAI, it would facilitate the PROs' monitoring of the adequacy of the discharge planning process performed by hospitals. PRO reviewers could use the UNAI to determine that a needs assessment had been conducted and that a discharge plan had been developed based upon identified patient needs. The potential for subjectivity in the review process would be decreased by specifying clear structure and process standards for the elements of the needs assessment process.

There are different expectations regarding the specific responsibilities of SNFs and home health agencies to perform a needs assessment as part of the discharge planning process. While generic screening criteria differ for SNFs and home health agencies, the intent is essentially the same as the criteria used to review hospital discharge planning. Should its use be required for nursing facilities and home health agencies, the UNAI could be used to facilitate the PROs' review of factors related to the adequacy of

discharge planning in the same fashion as was previously discussed for hospitals.

Assessment of a patient's needs for continuing care and development of a plan to address those needs are integral responsibilities of the health care professional in any setting. It is possible that criteria regarding the adequacy of the needs assessment process may even become part of the review of care provided in ambulatory settings, such as Health Maintenance Organizations (HMOs) and physicians' offices.

The Panel's deliberations focused solely on how the UNAI could be used in traditional survey and certification and PRO review programs to evaluate a provider's compliance with needs assessment and discharge planning requirements. A surveyor would review a completed UNAI while conducting the medical record review task currently performed during a survey of the facility. The PRO nurse would evaluate the UNAI as well as other portions of the medical record using HCFA's generic quality screens. Currently PRO review of clinical records occurs either on-site or in the PRO office using a copy of the record made available by the provider of service. As such, the UNAI would simply augment the amount of clinical material available for review in the current survey or PRO review process. However, if a UNAI is adopted and used in a different manner by regulatory agencies, additional safeguards to provide for the confidentiality of sensitive patient information may need to be developed.

---

## **OTHER QUALITY ASSURANCE STUDIES OF POST-ACUTE CARE**

### **Transitional care issues**

The UNAI also has utility for its potential role in studies undertaken to evaluate the quality of transitional and post-acute care. The UNAI could be integrated into review methodologies to study the appropriateness of decisions regarding post-acute care as based on identified patient needs. Quality assurance studies could also be focused on the adequacy of mechanisms geared toward facilitating continuity of care, such as the transfer of patient information to post-acute care providers.

### **Longitudinal studies**

While quality assurance efforts to date have focused primarily on the review of care within specific care settings, there is also a need for longitudinal data and mechanisms that more broadly examine the post-acute care trajectory. A more holistic approach that would allow patients to be followed across care settings to evaluate the appropriateness of post-acute care decisions should be considered. This might include a longitudinal study of the composite effectiveness of post-acute care, in which the UNAI could be

employed to assess a patient's unique needs and resources in an ongoing manner.

The use of standardized assessment processes to provide longitudinal data is summarized by Kane:

(Computerization of assessment data) ... can display information to show change over time, thus permitting both the regulators and the caregivers to look at the effects of care... It is not hard to envision a large data set that would permit calculations of expected courses for different types of long-term care clients. These could then be compared to individual client's courses to assess the potential impact of care on outcomes of importance (1990, p. 291).

## **C. USING THE UNAI TO COMPILE A NATIONAL DATA BASE FOR RESEARCH AND POLICY DECISIONS**

The Panel recognized that a new type of data base could be generated should use of the UNAI become required through regulation. Compilation of needs assessment data would result in a unique data base, focusing on the functional and social attributes of the elderly that are critical to the analysis of post-acute care issues. In general, previous data regarding Medicare beneficiaries, such as that compiled via the UB-82 system used for billing purposes,<sup>5</sup> has been based more on a

---

<sup>5</sup>The Uniform Billing (UB 82) system is a standardized billing form for hospitals, home health agencies and long-term care facilities. The data set contains 94 elements, though not all are applicable depending upon the setting in which care is rendered. It was designed for Medicare,

Medicaid and all third-party insurance billing, though individual State insurance companies may use the form in different ways. The system was developed by JRB Associates under a HCFA grant (Martin, 1988).

---

clinically-oriented medical model. However, data regarding specific medical diagnoses and the use of clinical procedures often do not reflect a patient's ability to function or their needs for care (National Research Council, 1988).

The need to incorporate measures of functional status and social support in data bases to predict long-term care needs has long been recognized. Typically, needs for long-term care have been evaluated by measuring the degree of assistance needed to perform everyday activities, generally classified as Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) ( General Accounting Office, 1988).

Additionally, the amount and type of health care services used by the elderly are very much influenced by the social support system available to them (Brody, 1981). The importance of a patient's current and potential support system cannot be underestimated, with the availability of informal supports playing a primary role in decisions regarding institutionalization. According to Doty (1986), informal support systems, by providing for approximately 80 percent of associated long-term care needs, allow nearly two-thirds of the impaired elderly to remain in the community. Clearly then, assessment of the patient's network of family and friends is vital to the identification of non-institutional options for continuing care that are needed to compensate for deficits in functional capabilities.

### **Use of data to support health policy decisions**

Difficult choices about resource allocation and program structure require reliable data upon which to plan for the multifaceted health care needs of an aging U.S. society. Issues related to the cost and accessibility of health care have long driven the political agenda, but recently there has been increased attention to quality-of-care issues, with a desire to improve the government's ability to evaluate the effectiveness of care provided to the elderly (Roper & Hackbarth, 1988).

A major issue in the health care debate concerns the elderly's needs for long-term care. By definition, long-term care encompasses care provided over an extended period of time, regardless of its setting. Information is needed to better understand the nature and intensity of long-term care needs. Current data bases have been judged inadequate to support policy decisions that shape the type and availability of services provided to the elderly (National Research Council, 1988). Because of variations in the methodology used to assess functional dependency, there is no consensus on the needs of the elderly for long-term care services ( General Accounting Office, 1988).

Policy makers require timely information regarding current use of services as well as data to project future needs based upon changes in relevant factors such as functional status and the availability of a support system. To project needs for long-term care, longitudinal data is required to reflect changes in the characteristics of the elderly population, their use of services, and the



---

nature of their support systems. Data required to project the cost of long-term care includes estimates of the amount and type of care that will be needed as well as an analysis of the extent that services meet the health care needs of the elderly. The development of such a data base requires periodic monitoring of the health status of the elderly and their use of health care services to detect trends and to forecast future health status and utilization of services (National Research Council, 1988).

### **Federal efforts to compile data regarding health care needs**

Federal, state and local agencies compile data to analyze and predict the health care needs of populations under their jurisdiction. Federal systems designed to collect data regarding demographic, social and economic characteristics as well as rates of morbidity and mortality, health expenditures and utilization are operated by the Bureau of the Census in the Department of Commerce and the National Center for Health Statistics (NCHS) in the Department of Health and Human Services (National Research Council, 1988).<sup>6</sup>

Additionally, in an effort to understand better the needs of an aging population, the Panel on Statistics for an Aging Population was established in 1984. Under the auspices of the Committee on National Statistics and within the Na-

tional Research Council, the Panel was charged with studying the adequacy of current statistical information and methodology, particularly in the area of health and medical care. A report detailing the Panel's recommendations as well as a critique of current data bases was published in 1988 (National Research Council).

In formulating recommendations regarding the development of new and/or modification of existing data sets related to health status and quality of life, the Panel on Statistics for an Aging Population recognized the need to:

- o build measures capable of assessing changes in an individual's ability to function (i.e., capable of detecting improvement over time rather than just losses in function), and
- o identify not only the setting in which care is provided but also the specific nature of that care (recognizing that the common practice of quantifying care needs according to the site in which care is rendered is increasingly misleading) (National Research Council, 1988, pp. 67-69).

The data gleaned from implementation of a uniform needs assessment system could address both of these concerns.

Another of the general recommendations made by the Panel on Statistics for an Aging Population concerned the need to standardize definitions and instrumentation across data collection and dissemination activities (National

---

<sup>6</sup> For more information, see Pearce's discussion on the development, testing and status of data sets recognized for

uniform use (1988).

---

Research Council, 1988). For example, most practitioners perform some type of assessment of functional status in determining an elderly patient's needs for continuing care, but definitions and methods used to assess functional capabilities vary widely. Standardization of assessment methodology would allow compilation of a national data base, the scope of which would extend well beyond those available to specific institutions or multi-site demonstrations. It would also provide a method for longitudinal assessment of patient progress; such information is needed to analyze outcomes of care provided by numerous providers or across a variety of care settings.

While calling for increased efforts to coordinate data elements to minimize unnecessary duplication (see Chapter 5), the Uniform Needs Assessment Advisory Panel also recognized the research benefits associated with adoption of standardized assessment methodology. The Panel suggested that, wherever feasible, data elements that are common across care settings be uniformly defined and efforts made to contribute to a uniform data set that could be used across settings.

Regular collection of standardized assessment data would have many benefits for both broad-based clinical research and facility monitoring of care. The potential uses of standardized assessment instruments are discussed by Kane:

The ability to compare observed and expected outcomes extends beyond its role as a regulatory device. It could be a major

source of assistance to care givers. One of the great frustrations in long-term care, especially in the trenches, is the difficulty to sense when you are making a difference. Because so many clients enter care when they are already declining, the benefits of care are often best expressed as a slowing of that decline curve. Without some measure of expected course in the absence of good care, those who render care daily may not appreciate how much they are accomplishing and thereby may forgo one of the important rewards of their labors (1990, p. 291).

#### **UNAI-derived data and HCFA's Uniform Clinical Data Set**

An additional data base, the Uniform Clinical Data Set (UCDS), is currently under development by HCFA. Intended as a more objective means to screen for admission and quality of care problems, it would standardize information collected by each PRO so that systematic comparisons of admission denials and quality of care problems could be made between PROs. In addition, a large epidemiologic data base would be created for use in the Department of Health and Human Services' effectiveness research initiative.

UCDS data will be compiled by abstracting relevant clinical data from the medical records of all inpatient admissions reviewed by the PROs, or approximately 20-25 percent of all Medicare admissions. PRO staff will be responsible for abstracting data either on-site or at a central office, entering data via laptop computers (Lohr, 1989).

While under ongoing refinement as part of field testing, the most current draft of the UCDS

---

has measures to assess a limited amount of information regarding the patient's functional status and caregiver arrangements at discharge. These items could be used to assist in the study of appropriateness of continued care.

Should a uniform system of needs assessment be adopted, the relationship of the UNAI to the UCDS should be studied. Consideration should be given to the potential utility of UNAI-derived data to supplement the UCDS's role in Federal quality assurance efforts.

Much of the patient information collected via the UNAI would enhance or complement the UCDS data base. Data derived from the UNAI would also have an additional advantage in that it would be compiled as a part of the facility's patient care responsibilities and would not require the additional expense of record abstraction by a PRO. The UNAI data base would also probably be larger and more focused on a high-risk population than that obtained through PRO review. Under the uniform system of needs assessment proposed by the Panel, all Medicare patients would be screened as the initial phase of the discharge planning process and an intensive evaluation of needs for continuing care (i.e., the UNAI) completed for those patients for whom it was clinically warranted.

#### **Use of UNAI-derived data within facilities**

Data compiled from the UNAI could also be used by individual facilities to identify gaps in services, inappropriate resources and other factors that adversely affect the provider's ability to

assess and arrange for needs for continuing care. Such information could be useful to facilities for long- and short-range planning by providing data to support the development or expansion of services to address the needs of their communities.

Data could also be used for the legislative advocacy efforts of administrative and professional staff members. Lobbying efforts, whether by individuals or collectively (via professional associations), are often directed towards influencing the policy decisions that will ultimately affect the availability of resources and options for continuing care. The data provided by a uniform system of needs assessment could therefore potentially be used to advance the concerns of all that are affected by or involved in continuity of care.

#### **Quality and confidentiality of aggregate UNAI data**

The quality of UNAI-derived data would be dependent on the development and implementation of a system to ensure reliability. Methods to ensure uniform use and interpretation of items, such as assessor training, as well as ongoing assessment of interrater reliability through an auditing process, would be necessary to establish the reliability and validity of the data base. Edit checks could also be built into the system to decrease the possibility of reporting erroneous data. Failure to develop adequate quality control procedures could compromise the utility of the UNAI as a data gathering vehicle.

---

The development of a UNAI data base would require that system specifications be established and that the responsibilities of providers as well as Federal and State governments be clearly defined through regulation. Necessary policy decisions include how often data would be transmitted, how data would flow to a central repository and how providers would be compensated for associated costs. In addition, a means to ensure the confidentiality of sensitive patient information would need to be created. Attention should also be given to constructing linkages of UNAI data with other Federal and State clinical and claims data bases.

#### **Advisory Panel conclusions**

Should a uniform system of needs assessment be implemented, the UNAI could be used to generate a clinically-oriented data base regarding the needs of Medicare beneficiaries. Data could be obtained on a variety of factors (e.g., general health status and risk factors, functional capabilities, nursing and other care requirements and the availability of social supports) that are needed to understand better and predict beneficiaries' needs for long-term care.

UNAI-derived data could be used as the basis for policy decisions and program development by identifying gaps in services and access constraints as well as predicting future needs for care. Data may also have utility for research, particularly in developing a better understanding of the effectiveness of care received by Medicare

beneficiaries. Longitudinal analyses of care provided by numerous practitioners or types of providers could be undertaken using outcome measures (such as functional status) derived from the UNAI.

#### **Summary**

Several implications of the uniform needs assessment initiative were discussed in this chapter. Panel deliberations and conclusions focused on the possible effects of a uniform needs assessment system on the liability of providers and professional staff responsible for assessing needs for continuing care. The potential role of a uniform system for needs assessment in activities designed to ensure quality and plan for the long-term care needs of Medicare beneficiaries was also discussed. Possible uses of the UNAI in Federal efforts regarding quality assurance and data base development were considered. The following chapter focuses on the possible use of the UNAI to determine eligibility for post-hospital and other long-term care services.

---

## References

- American Hospital Association, Office of General Counsel. Discharging hospital patients: Legal implications for institutional providers and health care professionals. Report of the Task Force on Legal Issues in Discharge Planning. Legal memorandum number nine. Chicago, Illinois: American Hospital Association, June 1987.
- Arcidiacono, K. Legal aspects of discharge planning. In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, 1988.
- Berkman, B. Quality assurance, utilization review, and discharge planning. In P. Volland (Ed.), Discharge planning: An interdisciplinary approach to continuity of care. Owings Mills, Maryland: National Health Publishing, 1988.
- Brody, E. Women in the middle. The Gerontologist, 1981, 21 (5), 471-480.
- 42 Code of Federal Regulations. Washington: U.S. Government Printing Office.
- Compilation of the Social Security laws (including the Social Security Act, as amended, and related enactments through January 1, 1989). Volume 1. Committee on House Ways and Means, 101st Congress, 2nd Session. Washington: U.S. Government Printing Office.
- Doty, P. Family care of the elderly: The role of public policy. Milbank Memorial Fund Quarterly. 1986, 64 (1), 34-75.
- General Accounting Office. Long-term care for the elderly: Issues of need, access, and cost. November 1988, GAO/HRD-89-4.
- Health Care Financing Administration. Second Scope of Work delineating PRO review functions, 1986-1988 contract cycle.
- Health Care Financing Administration. Third Scope of Work delineating PRO review functions, 1988-1991 contract cycle.
- Home health agencies: Conditions of Participation and reduction in recordkeeping requirements: Interim final rule. Federal Register. August 14, 1989, 54 (155), 33354-33373.
- Institute of Medicine, Committee on Nursing Home Regulation. Improving the quality of care in nursing homes. Washington, D.C.: National Academy Press, 1986.
- Kane, R. Standardized assessment as a means rather than an end. The Gerontologist, June 1990, 30 (3), 291-292.
- Libow, L. & Starer, P. Care of the nursing home patient. New England Journal of Medicine. July 13, 1989, 321 (2), 93-96.
- Lohr, K. Description of the uniform clinical data set of the Health Standards and Quality Bureau, Health Care Financing Administration. Unpublished paper developed for use in projects of the Institute of Medicine, National Academy of Sciences, July 1989.
- Martin, K. Nursing minimum data set requirements for the community setting. In H. Werley & N. Lang (Eds.), Identification of the Nursing Minimum Data Set. New York: Springer Publishing Company, 1988.
- Medicare Quality Protection Act of 1986. Brief summary of provisions. June 24, 1986.
- National Research Council, Panel on Statistics for an Aging Population. D. Gilford (Ed.). The aging population in the twenty-first century: Statistics for health policy. Washington, D.C.: National Academy Press, 1988.

---

O'Hare, P. An overview of discharge planning. In P. O'Hare & M. Terry (Eds.), Discharge planning: Strategies for assuring continuity of care. Rockville, Maryland: Aspen Publishers, Inc., 1988.

Pearce, N. Uniform minimum health data sets: Concept, development, testing, recognition for Federal health use and current status. In H. Werley & N. Lang (Eds.), Identification of the Nursing Minimum Data Set. New York: Springer Publishing Company, 1988.

Providing for reconciliation pursuant to section 2 of the concurrent resolution on the budget for fiscal year 1987 (OBRA 1986). Conference report to accompany H.R. 5300. October 17, 1986. Section 9305(c).

Report of the Committee on the Budget, House of Representatives. Committee report to accompany Public Law 100-203, H.R. Rep. No. 391, 100th Congress, 1st Session 411 (OBRA 1987).

Requirements for long term care facilities: Final rule with request for comments. Federal Register. February 2, 1989, 54(21), 5316-5373.

Revisions to Conditions of Participation for hospitals: Proposed rule. Federal Register. June 16, 1988. 53(116), 22506-22513.

Roper, W. & Hackbarth, G. HCFA's agenda for promoting high-quality care. Health Affairs, Spring 1988, 7 (I), 91-98.

Spence, D. & Weiner, J. Nursing home length of stay patterns: Results from the 1985 National Nursing Home Survey. The Gerontologist, February 1990, 30(1), 16-20.

---

## CHAPTER 7: EVALUATION OF THE ADVANTAGES AND DISADVANTAGES OF USING THE NEEDS ASSESSMENT INSTRUMENT FOR ELIGIBILITY DETERMINATIONS

The Panel's charter included a charge to evaluate the advantages and disadvantages of using the uniform needs assessment instrument (UNAI) as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to Medicare beneficiaries.<sup>7</sup> The Panel focused its study of this subject by examining information needed to make an eligibility determination regarding skilled nursing facility (SNF) and home health agency services under Part A of the Medicare program. The Panel also studied criteria used by some third party payers to determine eligibility for post-hospital services as well as the use of pre-admission tools by providers to predict eligibility for services.

The Panel's deliberations on this subject centered around the potential use of the UNAI as a vehicle to determine post-hospital benefits and the potential contributions of the UNAI to the process of eligibility determination for Medicare covered services. This chapter will provide background information and discuss the Panel's recommendations regarding these issues as well as present possible directions for further study.

### A. OVERVIEW OF ADMINISTRATION OF MEDICARE BENEFITS

Various components within the Health Care Financing Administration's (HCFA) central office are responsible for policy formulation and various operational aspects of administering the Medicare program. The ten HCFA regional offices are responsible for a wide range of administrative activities, including coordination and operational appraisals, program evaluation, and liaison with fiscal intermediaries (for Part A services) and carriers (for Part B services).

Fiscal intermediaries (FIs) are national, State or other public or private agencies that have entered into an agreement with HCFA to process Medicare claims received from providers of services. FIs review claims to determine whether services are covered and meet criteria regarding the appropriateness and necessity of services (Medicare Skilled Nursing Facility Manual, 1982; Medicare Home Health Agency Manual, 1983). In processing claims for post-hospital services, FIs review claims to ensure that they are accurately prepared for services rendered by SNFs, home health agencies and other providers, the patient is eligible for Medicare benefits, and that

---

<sup>7</sup>The process of "determining whether payment should be made for posthospital extended care services and home health services provided to Medicare beneficiaries" is referred to as "eligibility determination" throughout this chapter. The Panel used this term to describe the review process and resultant decision of whether a beneficiary

meets established criteria for medical necessity and is therefore eligible for Medicare covered services. This is different from HCFA's usual interpretation of eligibility, which generally refers more broadly to whether an individual is eligible for Medicare benefits.

---

payment is made only for Medicare covered services (A. Ringgold, Panel presentation, February 22, 1989).

Additionally, though primarily concerned with the review of acute care, the Peer Review Organizations (PROs) play a role in determining whether post-hospital care is reasonable and necessary, is provided in an appropriate setting and meets professional standards for quality care. PROs are authorized to deny payment for care that is not medically necessary or not delivered in an appropriate setting. PROs also review hospital notices of noncoverage issued to a beneficiary upon his or her request and respond to a hospital's request for reconsideration of PRO decisions (The Medicare Handbook, 1989). PROs therefore play an important utilization review function for the Medicare program.

## B. EVOLUTION OF BENEFITS PROVIDED UNDER THE MEDICARE PROGRAM

The Medicare program has drawn substantial criticism regarding its purported lack of financing for necessary post-hospital services. Factors such as the growing prevalence of individuals with chronic problems who require non-skilled, supportive care and the implementation of the Prospective Payment System, which shifted much care to ambulatory or non-acute settings (discussed in Chapter 2), have heightened providers' and beneficiaries' concerns regarding the ad-

equacy of financing for post-hospital services. However, the Medicare program, as outlined in 1966, was not designed to meet the elderly's needs for chronic care.

The Medicare program was modeled after private health insurance programs of the 1960s. Initial program benefits were designed to address short-term acute care needs almost exclusively and that focus persists today (Somers, 1985). Section 1862 of the Social Security Act prohibits payment for "custodial" care, which the Medicare Handbook defines as:

primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. Much of the care provided in nursing homes or by home agencies to persons with chronic, long-term illnesses or disabilities falls into this category. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine (1989, p. 22).

Access to the Medicare SNF benefit is restricted to 100 days and is available only after a hospitalization for individuals in need of skilled nursing care. The home health care benefit is more liberal. Initially, the program covered up to 100 home health visits per year by a part-time skilled nurse or therapist, under physician certification and supervision. More progressive than most private health insurance plans during that time, the program also covered use of a home health aide, if skilled care was required. In 1981, the home health benefit was liberalized, with the



---

prior hospitalization requirement and 100-visit limit removed (Somers, 1985). Recent challenges by the home care industry regarding benefit interpretations have led to a further expansion of reimbursable services.

Additional post-hospital benefits were included in the recently rescinded Medicare Catastrophic Coverage Act of 1988. During the Panel's study, HCFA was involved in developing systems to expand home health, skilled nursing facility and hospice benefits and to implement benefits related to home intravenous drug therapy, mammography screening, respite care and prescription drugs (Cohn, 1989). The Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234, repealed the post-hospital benefit expansions included in the Medicare Catastrophic Coverage Act before they were implemented.

The Medicare program is but one source of funding for post-hospital services, with needs for post-hospital services often financed through private insurance or a combination of funding from Federal programs such as Medicaid (Title XIX of the Social Security Act), Social Services (Title XX of the Social Security Act), Supplemental Security Income (Title XVI of the Social Security Act), Administration on Aging, Veterans Administration, and Housing and Urban Development, as well as State/local, voluntary and for-profit programs. These programs vary greatly in terms of covered services and the criteria used to determine an individual's eligibility for services. Due to the wide diversity among these complex

programs, the Panel restricted its evaluation of the needs assessment instrument for determining eligibility for benefits to the Medicare program only.

### C. INFORMATION REQUIRED TO DETERMINE ELIGIBILITY FOR POST-HOSPITAL SERVICES UNDER THE MEDICARE PROGRAM

An overview of the various types of criteria used to determine whether services should be provided to Medicare beneficiaries follows. Unless indicated otherwise, the following was abstracted from a presentation to the Panel on February 22, 1989, by Andrea Ringgold, Chief of the Provider Medical Review Branch of HCFA's Bureau of Program Operations.

In general, for services to be covered by Medicare, they must be reasonable and medically necessary for the treatment of an illness or injury. They must also be ordered by a physician. Custodial care, with the exception of hospice services, is excluded from coverage. Durable medical equipment is covered when reasonable, medically necessary and specifically ordered by a physician.

Several principles related to the scope, frequency and purpose of the service guide coverage decisions for SNF and home health care benefits.

---

### **Evaluation of eligibility for SNF services**

SNF services are covered under Medicare when the beneficiary requires skilled nursing or skilled rehabilitation services on a daily basis, and the daily skilled services can be provided only on an inpatient basis in an SNF. Daily is defined as seven days a week, with the exception of rehabilitation services that may not be available seven days a week; for those services, daily is considered to be five days a week. Skilled services are defined as those that must be performed by, or under the supervision of, professional or technical personnel for them to be provided in a safe and effective manner. In addition to being skilled, rehabilitation services must be provided with the expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time. Rehabilitation services may also be provided for the purpose of establishing a maintenance program.

In reviewing Medicare eligibility for SNF care, the FI must determine:

- o if the individual required skilled care on a daily basis;
- o if it was practical for the services to be provided in a SNF; and
- o if the services were reasonable and necessary as well as consistent with the nature and severity of the individual's illness or injury and accepted standards of medical practice.

In reviewing SNF services, the FI assumes that the "practical matter" criterion is met unless there is evidence to the contrary.

### **Evaluation of eligibility for home health services**

Home health care services are covered by Medicare when the services are provided under a physician's written plan of treatment, with the physician certifying or recertifying the need for home health services at intervals not exceeding 60 days. The beneficiary must be confined to the home as a result of illness or injury, and can only leave the home for the purpose of receiving medical treatment or infrequently for a short period of time. The beneficiary must also require skilled nursing care or skilled rehabilitation services (e.g., physical therapy or speech therapy) on an intermittent basis. Intermittent skilled services are defined as being more than a one-time visit, less than daily visits (less than a total of 35 hours per week), or provided daily for a predictable and finite period. Medicare does not cover full-time care in the home.

Skilled services include the management and evaluation of the individual's care plan; observation and assessment of the individual's condition, where unstable; teaching and training necessary to enable self-care; performance of direct services, such as injections, tube feedings, exercises, and other similar services; and the performance of direct services by an occupational or speech therapist. All skilled services

---

must be provided by a licensed health care professional (e.g., skilled nursing services must be provided by a registered nurse). In addition, the services must be prescribed and provided under the expectation that these services would materially improve the individual's capabilities in a generally predictable period. Services may also be prescribed for the purpose of establishing a maintenance program.

To determine whether home health services are covered by Medicare, the FI must determine:

- o if the individual was confined to the home;
- o if there was a physician's order for intermittent skilled nursing or physical/speech therapy services;
- o if the services required the skills of a professional nurse or therapist;
- o if the services met coverage guidelines; and
- o if the services were reasonable and necessary.

#### **Documentation required by FIs for eligibility determinations**

The following are general factors that must be documented by SNF and home health care providers submitting claims for FIs to use in determining eligibility for Medicare reimbursement:

- o the primary diagnosis and date of onset or exacerbation;

- o type and date of surgical procedures (if any);
- o pertinent secondary diagnoses (i.e., those that have an impact on treatment of the current condition);
- o pertinent medications, including dosage and route of administration;
- o type, amount, frequency and duration of services ordered by the physician;
- o the patient's functional level and restrictions that are imposed by the medical condition;
- o a description of the patient's current clinical condition;
- o the treatment or rehabilitation goals;
- o the availability and accessibility of required services in the community; and
- o the degree to which the services can safely and effectively be provided in the home or another outpatient setting.

Within these general categories, specific information must be provided by both home health agencies and SNFs.

#### **Process used by the Fiscal Intermediaries to review claims**

In some cases, HCFA mandates the type and frequency of review that the FI performs. For SNF claims, the FI reviews 45 percent of claims, which are selected randomly or through the use

---

of screening mechanisms, such as length of stay. Unlike home health claims, no specific form has been developed for national use to document SNF services.

For home health agency claims, the FI reviews the initial claim in the certification period and the first claim in the recertification period. In order for the FI to review a claim, home health agencies must document their plan of treatment and other information related to medical necessity on specific forms: HCFA 485, 486, 487 and 488 (Exhibit 7-1). These forms have been developed to provide structure for the specific information that is needed by the FIs to make decisions regarding eligibility for home health services. Some FIs use an automated system to screen coded information from the forms.

Verification of “medical necessity” implies that a physician must write an order or sign a form to document his or her approval for skilled care in a nursing facility or in the home. FIs do not normally require copies of signed physician orders or signed plans of treatment. However, the home health agency or SNF must retain these on file as they may be requested by the FI on an exception basis or reviewed during post-payment audits.

#### **D. USE OF THE UNAI FOR ELIGIBILITY DETERMINATIONS**

The Panel concluded that the UNAI as designed would not collect all the information re-

quired by FIs to make eligibility determinations for post-hospital services under Part A of the Medicare program. Several issues impede its use in this manner.

The Panel used a clinical framework in constructing the UNAI to contain the minimal information necessary to determine continuing care needs (see Chapter 4). When possible, items were devised to be consistent with Medicare eligibility criteria (i.e., definitions regarding functional status were refined to be consistent with criteria used to make decisions for “homebound” status), but the Panel did not allow eligibility criteria to drive the content of the instrument. The Panel believed that doing so would detract from the clinical utility of the instrument, whose primary purpose was defined as “to determine a patient’s needs for continuing care.”

The Panel was charged by Congress with developing a needs assessment instrument based on measures of functional status, nursing and other care requirements and social and familial support. The literature supports the Panel’s view that such a functional/social framework is the foundation of the clinical determination of needs for post-hospital and other long-term care services (see Chapter 3). The orientation of the Congressionally-mandated needs assessment instrument is consistent with the state-of-the-art in the delivery of long-term care services. However, it is in conflict with the approach upon which the Medicare program originally defined eligibility for post-hospital services. Though some fine-tuning of eligibility requirements has

# EXHIBIT 7-1

Department of Health and Human Services  
Health Care Financing Administration

Form Approved  
OMB No. 0938-0357

## HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT

1. Patient's HI Claim No.		2. SOC Date		3. Certification Period From: To:		4. Medical Record No.		5. Provider No.	
6. Patient's Name and Address					7. Provider's Name and Address				
6. Date of Birth:					9. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F				
11. ICD-O-CM Principal Diagnosis					Date				
12. ICD-O-CM Surgical Procedure					Date				
13. ICD-9-CM Other Pertinent Diagnoses					Date				
14. DME and Supplies					15. Safety Measures:				
16. Nutritional Req.					17. Allergies:				
<b>18.A. Functional Limitations</b> 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Pudipis 9 <input type="checkbox"/> Leselyy Blind 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input type="checkbox"/> Ert6mc.a A <input type="checkbox"/> Dyspnea With Minimal Exertion 3 <input type="checkbox"/> Contracture 7 <input type="checkbox"/> Ambulation B <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech					<b>18.B. Activities Permitted</b> 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> E&resEIFiP 7 <input type="checkbox"/> Crutches B <input type="checkbox"/> Walker No Restrictions 3 <input type="checkbox"/> Up As Tolerated 9 <input type="checkbox"/> Cane C <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Transfer Bed/Chair 5 <input type="checkbox"/> Exercises Prescribed 6 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 8 <input type="checkbox"/> Depressed 6 8 <input type="checkbox"/> Other 20. Prognosis: 1 <input type="checkbox"/> Guarded 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)									

22. Goals/Rehabilitation Potential/Discharge Plans

23. Verbal Start of Care and Nurse's

Signature and Date Where Applicable:

24. Physician's Name and Address

25. Date HHA Received  
Signed POT

26. I ☐ certify ☒ recertify that the above home health services are required and are authorized by me with a written plan for treatment which will be periodically reviewed by me. This patient is under my care. is confined to his home, and is in need of Intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need and no longer has a need for such care or therapy, but continues to need occupational therapy.

27. Attending Physician's Signature (Required on 485 Kept on File in Medical Records of HHA)

Date Signed

## EXHIBIT 7-1 (continued)

Department of Health and Human Services  
Health Care Financing Administration

Form Approved  
OMB No. 0936-0357

MEDICAL UPDATE AND PATIENT INFORMATION				
1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No
6. Patient's Name		7. Provider's Name		
8. Medicare Covered: <input type="checkbox"/> Y <input type="checkbox"/> N		9. Date Physician Last Saw Patient:	10. Date Last Contacted Physician:	
11. Is the Patient Receiving Care in an 1661 (J)(I) Skilled Nursing Facility or Equivalent? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Do Not Know		12. <input type="checkbox"/> Certification <input type="checkbox"/> Recertification <input type="checkbox"/> Modified		
13. Specific Services and Treatments				
Discipline	Visits (This Bill) Rel. to Prior Cert.	Frequency and Duration	Treatment Codes	Total Visits Projected This Cert
14. Dates of Last Inpatient Stay: Admission		Discharge	15. Type of Facility:	
16. Updated Information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline				

17. Functional Limitations (Expand From 465 and Level of ADL) Reason Homebound/Prior Functional Status

18. Supplementary Plan of Treatment on File from Physician Other than Referring Physician:  
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)

☐ Y ☐ N

19. Unusual Home/Social Environment

20. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable

21. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence

22. Nurse or Therapist Completing or Reviewing Form

Date (Mo., Day, Yr.)

Form HCFA-466 (C3) (4-87)

PROVIDER

## EXHIBIT 7-1 (continued)

Department of Health and Human Services  
Health Care Financing Administration

Form Approved  
OMB No. 0938-0357

**ADDENDUM TO:** ☒ **PLAN OF TREATMENT** ☐ **MEDICAL UPDATE**

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.
6. Patient's Name			7. Provider Name	
8. Item No.				
8. Signature of Physician			10. Date	
11. Optional Name/Signature of Nurse/Therapist			12. Date	

Form HCFA-487 (U4) (4-87)

PROVIDER

## EXHIBIT 7-1 (continued)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED  
OMB NO. 0938-0357HOME HEALTH AGENCY  
INTERMEDIARY MEDICAL INFORMATION REQUEST

1. Initial Request Date:	2. Final Request Date:	
3. Provider Number:	4. Document Control Number:	
5. Patient Name:	6. HI Claim Number	
7. Medical Record Number:	8. Period of Claim: From: To:	9. SOC Date
<input type="checkbox"/> 10. HCFA-485/486: Period Covered:	<input type="checkbox"/> 11. HCFA-486: Period Covered:	
<input type="checkbox"/> 12. Frequency of doctors visits:		
<input type="checkbox"/> 13. Status of chronic condition:		
<input type="checkbox"/> 14. List primary need for: <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="checkbox"/> SN    <input type="checkbox"/> PT    <input type="checkbox"/> ST    <input type="checkbox"/> OT    <input type="checkbox"/> MSS    <input type="checkbox"/> HHA    <input type="checkbox"/> Other Visits </div>		
<input type="checkbox"/> 15. List dates of visits for: <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="checkbox"/> SN    <input type="checkbox"/> PT    <input type="checkbox"/> ST    <input type="checkbox"/> OT    <input type="checkbox"/> MSS    <input type="checkbox"/> HHA    <input type="checkbox"/> Other Visits </div>		
<input type="checkbox"/> 16. Laboratory tests (frequency, types, results):		
<input type="checkbox"/> 17. Other tests (frequency, types, results):		
18. Diet <input type="checkbox"/> Type <input type="checkbox"/> Teaching Duration <input type="checkbox"/> Compliance <input type="checkbox"/> Length of time on the diet		
<input type="checkbox"/> 19. Date(s) on which frequency of SN or HHA increased or decreased:		
<input type="checkbox"/> 20. Specific progress notes for: <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <input type="checkbox"/> SN    <input type="checkbox"/> PT    <input type="checkbox"/> ST    <input type="checkbox"/> OT    <input type="checkbox"/> MSS    <input type="checkbox"/> HHA    <input type="checkbox"/> Other Visits </div>		
<input type="checkbox"/> 21. Reason for continued Medicare coverage:		
<input type="checkbox"/> 22. Doctor's orders, signed by physician		
<input type="checkbox"/> 23. Supplemental Plans of Treatment, if applicable:	24. Signature of F.I. Representative	

Form HCFA-488 (U2) (4-87)



---

occurred during the past twenty-five years, the Medicare program bases eligibility for post-hospital services on a medical model, with criteria strictly defined according to precise variables.

The Panel did not believe that it was possible to develop a needs assessment instrument for the dual purposes of clinical decision-making and eligibility determination under the current Medicare program. The Panel believed that the process of decision-making for long-term care needs requires more and different types of information than is needed by FIs to determine eligibility for post-hospital services covered under Medicare Part A. Conversely, some of the specific information required by FIs to determine eligibility is of little use to clinical decision-makers.

Additionally, there are differences in the content and level of detail required to determine eligibility for both SNF and home health services. This prohibits the development of any one simplistic form or set of forms for FI review that could be initiated by the provider responsible for performing a “clinical” needs assessment and arranging for all continuing care services covered by Medicare. The Panel determined that adding the details necessary to determine eligibility for both SNF and home health services to the UNAI would detract from its ability to be used by professional staff responsible for the clinical task of needs assessment.

### **Advisory Panel conclusions**

The UNAI does not contain all of the information currently required to determine eligibility for post-hospital services covered under the Medicare program. The Panel also determined that it was not feasible to expand the UNAI to contain this additional information. Therefore, the Panel recommended that:

The needs assessment instrument should not be used as a primary vehicle to convey information for eligibility determinations.

### **E. POTENTIAL CONTRIBUTIONS OF THE INSTRUMENT TO THE PROCESS OF ELIGIBILITY DETERMINATION**

While the Panel did not support use of the UNAI as the sole vehicle for eligibility determinations, it did recommend that it could be used to supplement the current process. It recommended that:

The instrument could make a positive contribution to the eligibility determination process by providing a more complete picture of the patient’s needs for care.

Areas in which the UNAI could potentially be used to supplement the current eligibility process follow:

- o **Improving the data base on which eligibility determinations are made.**

Provision of UNAI data to FIs would provide a more complete picture of the

---

beneficiary's clinical status and care needs; and

0 **Improving the consistency of eligibility determinations.**

The current eligibility determination process has been criticized as being too subjective and open to the interpretation of FIs. This issue has been the subject of numerous studies and GAO reports. In recreating the impetus for the uniform needs assessment initiative, a Congressional staff person cited reports of:

...frequently unpredictable and inconsistent determinations being made for the Medicare skilled nursing facility and home health care benefits. ... (this) was making it much more difficult for hospital discharge planners and/or providers to anticipate whether there would be reimbursement, and therefore plan for the care of patients, whether they were coming from the hospital or from somewhere else (D. Schulke, Panel presentation, June 1, 1988, transcript p. 52).

In presenting the underlying Congressional intent for the UNAI, the staff person added "we hope that it will improve the relevance and accuracy of eligibility determinations for Medicare home health and skilled nursing facility services" (D. Schulke, Panel presentation, June 1, 1988, transcript pp. 55-56).

The UNAI could be submitted along with other necessary documentation by providers of post-hospital services. If a uniform system of needs assessment were implemented, the UNAI would have been completed by professional staff employed by the transferring provider. The re-

ceiving provider would then need to ensure that the UNAI still reflects the beneficiary's current status (in case his or her status has changed from the time the UNAI was completed) prior to submission to an FI for a retroactive determination.

Use of the UNAI in this way would allow:

- o Uniformity in the presentation of beneficiary needs and current health status\*. The content of supplementary data submitted for each claim would be the same in different geographical areas of the country and across different organizations that act as FIs;
- o Uniformity in the methods (terminology and rating scales) used to document supporting information for each determination decision. This would facilitate the review of questionable cases and allow comparison with determinations based on similar cases. Decisions could then be more clearly substantiated or overturned; and
- o Development of uniform guidelines, operational systems and procedures for reviewing claims and making eligibility determinations based on information collected by the UNAI. This could improve the consistency of interpretations made by various FIs regarding medical necessity requirements. More functionally based measures of a beneficiary's status and care needs (as described by the UNAI) could be integrated into HCFA's policies for interpretation of eligibility requirements that are distributed to the FIs. This same approach could be used to standardize training received by reviewers responsible for making eligibility determinations.

---

### **Improving the discharge planning process for providers and beneficiaries**

The Panel addressed whether it would be possible to use the UNAI prior to discharge from one setting to determine eligibility for appropriate continuing care settings. This would probably not be possible under the current process of medical necessity review for Medicare covered services. However, some representatives of third party payers felt it may be possible for the private sector to use this approach, if the assessment was performed early in the course of a hospital stay and communicated to an insurer to make an initial eligibility determination (M. Cassell, Panel presentation, February 22, 1989; S. Mays, Panel presentation, February 22, 1989). The initial determination, however, would need to be verified at a later date as changes in the individual's status or care needs may result in another determination.

Such an approach would be advantageous in several respects. It was felt that this would assist the discharge planner in developing a plan that meets the patient's care needs and preferences, within the patient's financial limitations to afford services. For example, the discharge planner could explore the costs related to several potential post-hospital care options (with respect to the insurer's eligibility determination), 'present this information to the patient, and make appropriate arrangements based on the patient's decision.

In terms of benefits to the patient, more information could be provided to the patient

before discharge on services that would probably be covered and the anticipated personal costs that may be incurred. Because cost considerations frequently affect the selection of post-hospital care arrangements, a better informed patient will be more able to make decisions regarding continuing care arrangements. This process may also enable the patient to appeal an unfavorable decision regarding eligibility for post-hospital services prior to discharge.

The advantages associated with this process are substantial enough that it merits further investigation. However, the Panel made no formal recommendation in this vein as the UNAI does not contain all of the information needed to make an eligibility determination under the current Medicare program.

### **F. OTHER POTENTIAL USES RELATED TO ELIGIBILITY DETERMINATION**

#### **Use of the UNAI by third party payers**

As discussed previously, the Panel explored the potential use of the UNAI by the private sector through consultation with experts representing third party payers that provide benefit programs for post-hospital services. The types of information required by these organizations to determine eligibility for services is similar and in some cases, expands upon that required by FIs to determine eligibility for Medicare benefits. How-

---

ever, some third party payers utilize a case management approach to determine eligibility for post-hospital benefits. These experts believed that the UNAI could be helpful in presenting relevant information regarding the beneficiary's needs and capabilities in order to establish medical necessity for services (M. Cassell, Panel presentation, February 22, 1989; S. Mays, Panel presentation, February 22, 1989).

UNAI areas of potential utility are critiqued below:

- o **Health status:** Health status information is necessary to make an eligibility determination. The mental health status information is required, in some cases, to determine appropriate care settings. This information could assist insurers in identifying those settings that would not offer appropriate services (e.g., independent living arrangements may not be appropriate for a cognitively impaired individual).
- o **Functional status:** This information is necessary but may not be detailed enough for eligibility determination purposes. It may be necessary to supplement the information collected in this section with information collected by another assessment or by requesting additional information (in the form of specific examples of functional limitations) from the assessor.
- o **Environmental barriers:** This information would be very useful to insurers in identifying special considerations, on a case by case basis.

o **Nursing and other care needs:**

This information would provide much necessary information as well as include information that could be useful for determining eligibility for individuals with special needs. However, some information required to make eligibility determinations is not included (as different insurers or benefit packages have their own detailed information requirements).

o **Family and community resources:**

This information could be helpful in more fully understanding the patient and his or her social and community support network. However, the information would not, in most cases, affect the eligibility determination made by the insurer.

o **Patient and family goals and preferences:**

This information would be very important to ensure that every effort is made to provide preferred services before exploring other care options.

**Use by providers to predict eligibility for post-hospital services**

Providers of post-hospital services have long voiced their concerns regarding the period of time needed to establish whether they will be reimbursed by Medicare for services rendered and the risks they encounter in providing care to Medicare beneficiaries in the interim. Providers may render SNF or home health care services in good faith, which are later denied when claims are submitted for Medicare reimbursement. This issue was addressed in an adjacent section of the Omnibus Budget Reconciliation Act of 1986

---

(OBRA '86) that mandated the development of a uniform needs assessment instrument.

Section 9305(k) of OBRA '86 authorized the conduct of a demonstration program concerning prior and concurrent authorization for Medicare post-hospital extended care and home health services.<sup>2</sup> The law required the Secretary to study:

- o the administrative and program costs for prior and concurrent authorization as compared to the current system of retroactive review;
- o the impact of prior or concurrent authorization on access to and availability of post-hospital services as compared to the current system; and
- o the accuracy and associated cost savings of payment determinations and rates of claim reversal under prior or concurrent authorization versus the current system.

Providers' interests were not the only concerns at stake. The Conference report that accompanied the legislation reflected the Senate's interest in whether the process could be used to protect beneficiaries against liabilities incurred as a result of claim denials (1986).

OBRA '86 also contained provisions extending waiver of liability provisions to hospice pro-

grams (Section 9305(f)) and to home health agencies for certain coverage denials (Section 9305(g)).

In view of these concerns, the use of the UNAI by providers to predict eligibility for post-hospital services was considered (V. Reublinger, Panel presentation, February 22, 1989; J.. Ollis, Panel presentation, February 22, 1989). It was felt that this goal may be more feasible for SNFs than home health agencies as home health agencies have more stringent requirements regarding the content and process used to document the patient's status in claims submitted for FI review:

As previously discussed, home health agencies currently use several forms (HCFA 485, 486, 487 and 488) in submitting claims to FIs that document medical necessity for services rendered. It was felt that this process could not be replaced by a more "all purpose" tool, such as the UNAI, as it would not provide sufficient information to FIs to support eligibility decisions.

The Panel determined that, overall, the UNAI could be used in current public and private insurance eligibility determinations for post-acute care services only to supplement, rather than replace, other processes used to collect necessary information.

---

<sup>2</sup>This demonstration was completed by HCFA's Office of Research and Demonstrations under contract with Lewin/ICF.

---

## G. USE OF NEEDS ASSESSMENT METHODOLOGIES IN PUBLIC POLICY

An efficacious means of determining who is to receive what service or mixture of services is critical to the appropriate allocation of limited health care resources. If increasing numbers of older Americans are going to have an opportunity to receive necessary long-term care services, their needs must be assessed and matched with those services that are available and suitable to meet their needs (Pegels, 1988).

### **Support for the development of needs assessment methodologies**

The concept and practice of using “needs assessment” methodology as a means of determining an individual’s eligibility for long-term care services is well documented throughout the literature. Support for a needs assessment methodology in public policy was summarized in the following Policy Statement on the Elderly and Functional Dependency by the Institute of Medicine, National Academy of Sciences:

The federal government should reimburse for long-term care provided to the functionally dependent elderly. **Long-term** care should include both health and social services and should provide for choices between institutional and home-based care. Eligibility for federal reimbursement of long-term care should be based on a comprehensive assessment process (IoM, 1977).

Needs assessment methodologies based on relevant clinical assessment findings have been recommended to serve a “gate-keeper” function for long-term care services as well as to assure the appropriateness of care to meet the individualized needs of beneficiaries. Unfortunately, research and anecdotal evidence support the conclusion that inappropriate types of care have often been provided, with either too much or too little care given in relation to an individual’s needs. Inappropriate care may result when functional and social assessments are not used as the basis for long-term care decision-making.

However, there are other issues that contribute to the delivery of “inappropriate” care. Anecdotally, the Panel found that many propose that care decisions are often driven by the criteria used to establish eligibility for services funded by public programs or third party payers (i.e., that the type of care beneficiaries receive is dependent upon what they are “eligible” for, as opposed to what they actually “need.”)

For example, though a clinical assessment may indicate that community based care would be most appropriate for an individual, resource constraints may prohibit the use of suitable services. This may result in “not enough care,” with the beneficiary choosing to remain in the community without the supportive services that are truly needed or “too much care,” with the beneficiary opting for institutional care and a more restrictive environment than is necessary. Additionally, the Panel recognized the fact that “inappropriate care” may also be provided when ben-

---

eficiaries choose an arrangement for continuing care that is in conflict with the clinician's judgment regarding necessary services.

Inappropriate use of services, particularly skilled nursing services, has been cited in a number of studies; for example, up to 40 to 50 per cent of patients in nursing homes have been assessed as needing less (or a lower level of) care than they received (Williams, Hill, Fairbank et al., 1973; Williams & Williams, 1982). Similarly, studies have shown that between 20 and 40 percent of the residents of intermediate care facilities could be cared for in the community if supportive services were available (GAO, 1982). Thus, without adequate assessment and appropriate decision-making, elderly persons may receive care in an institutional setting when less confining community-based care (i.e., congregate living situations or living at home with support services) may have been possible. Conversely, an individual may not receive enough care (i.e., of the type or intensity that he or she needs). This may place the individual at risk or result in poor outcomes, such as acceleration of a disability or burnout on the part of family caregivers (Williams, 1983).

Inappropriate use of long-term care services is undesirable on several counts:

- 0 it is wasteful of scarce resources;
- o it can create further disability by leading to premature labeling of an individual as having a permanent incapacity; and

- o institutional environments are associated with an increased risk of complications or other morbidities for the elderly.

The role of clinical assessment as the basis for post-hospital care decision-making and in improving the appropriateness of placement is substantiated by a considerable and ever-widening body of research (Rubenstein, 1983).

### **Task Force on Long Term Health Care Policies**

The Task Force on Long Term Health Care Policies, as mandated by the Consolidated Omnibus Reconciliation Act of 1985, explored many issues surrounding the financing and administration of long-term care benefits by the private sector. The role of needs assessment methodologies to determine eligibility for benefits provided by the private sector was critiqued. Many parallels can be made regarding the use of needs assessment methodologies for eligibility determinations in public programs.

The Task Force's report to Congress and the Secretary contained several relevant principles regarding eligibility determination and the administration of long-term care benefits:

In the absence of a specific "event", long-term care insurance must define an entry point when people become eligible for benefits that is clear to the insured, not too complicated to administer and reasonably consistent in its application. ... Traditionally, eligibility has depended on the level

---

of care<sup>3</sup> required, that is, the need for skilled, intermediate or custodial care in a nursing home setting. ... Coverage and benefits based on level-of-care determinations are likely to be confusing to the insured and difficult for the insurer to administer. ... Determinations of levels of care for non-institutional settings are likely to be even more inexact and diverse. ... The questions remain how to determine when insurance payments will begin and under what circumstances they will continue (1987, p. 57).

The Task Force considered three alternatives for determining a beneficiary's level of coverage:

- o requiring each policy to define various levels of care independently;
- o establishing uniform national definitions of service and levels of care; and
- o using anew system of eligibility based on existing needs assessment systems.

The Task Force supported the use of a needs assessment system in that it can provide a greater degree of certainty in defining when insurance

coverage begins. Needs assessment methodologies based primarily on measurement of functional status (i.e., ability to perform activities of daily living) have proven to be highly reliable and consistent. However, there are special populations, like those with Alzheimer's disease, for whom the needs assessment system may not be completely appropriate. Dementia patients may demonstrate functional incapacities but their deficiencies tend to be sporadic rather than chronic. For this reason, the accuracy of the overall assessment may be improved by adding measures of behavioral dysfunction.<sup>4</sup>

A needs assessment system can also have great utility in promoting the use of appropriate home and community-based services. The Task Force found that most needs assessment systems use an interval level scale to evaluate an individual's status in measures such as performance of activities of daily living. Points are used to establish levels of dysfunction, which translate into a summary score reflecting the "need" for long-term care services. An insured person would become eligible for benefits when

---

<sup>3</sup>The level of care framework has traditionally been used to define eligibility in the Medicare and Medicaid programs. Medicare benefits have been rendered through skilled nursing facility coverage, with coverage criteria primarily defining "need" for care as a continuation of acute care services received in a hospital setting. Medicaid programs have differentiated between levels of nursing home care to determine reimbursement rates. Subject only to broad Federal parameters, the States have considerable latitude in defining levels of care and establishing Medicaid eligibility criteria (Grimaldi & Jazwiecki, 1987). Consequently, criteria used to determine level of care in

different States vary significantly, so that there is a wide variation in placement similarity across States (i.e., ranging from 38 to 91 percent according to a 1980 study by Foley and Schneider).

<sup>4</sup>Measures of behavioral status have not tended to have the same degree of reliability as those used to measure capabilities related to activities of daily living. Additionally, the assessment of behavior may be obtained from a third party caretaker, who may have an interest in qualifying the insured for benefits.



---

he or she reaches a specified level on the needs assessment scale. This approach would permit the insured to obtain benefits, if the provider of services is qualified to provide the needed level of services and if the services are provided in a covered setting. The use of a needs assessment system can thus shift the basis for eligibility from an issue of level of care to an issue of the extent to which the insured person needs long-term care.

In the judgment of the Task Force, the advantages of shifting to a needs assessment system to establish eligibility standards for long-term care insurance greatly outweigh the advantages of continuing to use the level-of-care method by:

- o Avoiding conflicting definitions of levels of care across States;
- o Providing a more objective basis for determining eligibility for benefits;
- o Assuring that individuals who have equal needs for care receive equal benefits regardless of the setting in which care is provided, thereby removing the institutional bias of access to care; and
- o Encouraging a managed care concept (1987, p. 58).

However, the Task Force also proposed that the use of a needs assessment system to determine benefit eligibility presents some diffi-

culties: There is less actuarial data based on needs assessment as opposed to level of care, at least for differentiating between skilled, intermediate and custodial care. There are also numerous systems in use across the country and they differ in their measurement methodologies, making comparisons among programs difficult.<sup>5</sup> Additionally, it is not clear how and by whom the needs assessment would be performed. Implementation of needs assessment methodologies requires education for those who must apply the standards.

Another problem concerns the reliability of data on which decisions would be made. Needs assessment systems often rely on the observations of beneficiaries and reports by caretakers about beneficiaries that may not be reliable. There may be a degree of legal uncertainty with a tendency on the part of assessors to avoid controversy by deciding close calls in favor of the beneficiary (Gustafson, 1984).

Any system can be manipulated to some extent, and the needs assessment system, since it relies on observation and reports from individuals with an investment in the eligibility decision is no exception. However, the Task Force also found that if the severity of need is fairly high in order to be eligible for benefits, and the assessors receive some training, 'the likelihood of serious distortion should be low if the needs assessment experience of the channeling demonstration is

---

<sup>5</sup>The Task Force found that some State governments report successful use of needs assessment methodologies by Medicaid programs to reduce utilization of unnecessary services.

---

generalizable. Yet, while admitting the current level of care system is unreliable, the Task Force found that some insurers do not believe that enough evidence is available to justify its replacement by needs assessment systems.

The Task Force's analyses of the advantages and disadvantages of needs assessment methodologies for the private sector can be used to extrapolate relevant concerns for public programs. The following conclusions can be made regarding use of a needs assessment approach in determining eligibility for publically funded long-term care services:

- o Needs assessment systems provide an objective basis for determining eligibility for benefits and avoid the necessity of determining the service to be provided and the level of care needed. The establishment of necessity and the insured person's own selection of a service setting are a more effective means of arriving at appropriate care;
- o Use of a uniform approach to needs assessment as a basis for eligibility instead of level of care and service determinations makes it possible to avoid conflicting definitions among "insurable events" for various programs (e.g., State Medicaid programs);
- o Use of a needs assessment approach ensures that the insured person is equally in need of care regardless of whether it is provided in an institution, at home, or in another community-based setting; and
- o Incentives to utilize informal care alternatives can be built into the benefit

eligibility determination using needs assessment methodology (1987, pp. 151-152).

#### Inconsistencies in needs assessment methodologies

As previously discussed, various public programs use needs assessment instruments to determine eligibility for benefits, but the tremendous variation in programs and available services has precluded the development of a standardized approach. Obviously there is a need for ongoing dialogue between providers and fiscal intermediaries, with much of this communication couched in the language of assessment. One problem is the lack of uniformity in eligibility criteria. Unfortunately, this problem is compounded by lack of standardization in the terminology used to describe a beneficiary's status in communication between providers and FIs.

Inconsistencies resulting from lack of standardization are evident in reviewing post-hospital utilization patterns for both SNF and home health care among the States (Neu & Harrison, 1986). Additionally, varying criteria used to determine eligibility for Medicaid cause even more discrepancies in nursing home utilization. For example, when criteria used to determine eligibility in New York State were applied to residents in Colorado nursing homes, 90 percent of the residents were eligible as compared to 40 percent in Illinois (Kane & Kane, 1981). It would be of value to have interstate agreement in this area, since Medicaid nursing home patients

---

may, for one reason or another, have to be transferred from one state to another. This now requires a whole new evaluation to be done.

The need for more uniformity in the eligibility determination process is well-documented, as are the advantages associated with use of a needs assessment approach in future expansions of public programs to address long-term care needs. However, this is not to suggest that a needs assessment methodology should be used to reform the current process of administering benefits for post-hospital services under the Medicare program. Rather this discussion is intended to provide a basis for future health policy deliberations.

#### H. DEVELOPMENT OF A UNIFORM NEEDS ASSESSMENT INSTRUMENT FOR ELIGIBILITY DETERMINATIONS

##### **Difficulties inherent in the development of a uniform instrument**

The dramatic growth in needs for long-term care services has long been recognized but issues regarding who should provide and how eligibility for services should be established is less clear. The factors that should be included in a needs assessment have received much attention and are documented throughout the literature. However, the question of how to weigh their relevance in the care needs equation has not yet been verified

by research and is open to debate. Former HHS Chief of Staff Tom Burke addressed many of the inherent difficulties behind these decisions:

The amount and kind of services needed by an individual do not depend simply on a person's condition. Rather, they depend on the living arrangements available, the availability of family and friends, the presence of community services and other nonmedical factors. This diversity of health needs, intermingled with social needs for housing, meal services, transportation and assistance with household management, makes centrally developed and regulated approaches less likely to be appropriate, since choices are generally constrained. Public programs, which must achieve uniformity and equity, have much more difficulty in offering both choice and cost control. One may assume that the availability of financing resources will affect the decision process in some way. ... Ideally, the financing available would allow families to avail themselves of nursing home care when the disabled person is too sick to be cared for at home or when providing the care places too great a strain on the resources of the family. The system should also encourage the availability of other services that support family caregiving, such as home, respite, and adult day care (1988, pp. 2-3).

Clearly a means to evaluate eligibility in terms of relevant factors is needed. Yet, the need to foster freedom of choice and increase the number of options available to an individual remains paramount. Brubaker describes the "long term care triad" of an elderly patient, family members and bureaucracy, and the factors that influence this relationship. He notes that bureaucracies and patients/families often conflict with

---

each other because of differences between what bureaucracies are equipped to provide and what patients and families want. By Brubaker's definition, bureaucracies are organized to provide uniform types of services within defined situations and settings. And by definition, patients and families are individuals with unique needs (Brubaker, 1987).

Can clinically based needs assessment methodologies be designed to individualize the beneficiary determination process? Somers adds the following:

What is needed is recognition of the facts that both institutional and noninstitutional modalities are needed and appropriate in given situations, depending partly on the level and duration of care needed, partly on the availability of family and other informal supports; that neither patients nor their care-givers should be locked into any one modality; and that some way must be found-through objective functional assessment, case management, patient cost-sharing, appropriate reimbursement policies, tax incentives for family care, respite services, family education, etc.-to facilitate flexible access to the broad range of services that will make possible the most cost-effective, as well as health-effective, use of all our long-term care resources, including long-term hospitals (1985, p. 224).

Additionally, Evashwick and Weiss call for the creation of a flexible system. While the goal of a continuum of care is to assist individuals to achieve their highest possible level of health and functional independence by guiding patients over time through appropriate levels of care, there is

tremendous diversity in care continuums, which are "local and unique to each community, built upon the resources, environment, and corporate culture of each organization" (1987, p. 397.)

### **Decision-making concerns**

In developing a needs assessment methodology on which to base eligibility determinations, it would be necessary to establish precise mechanisms to define eligibility for services. Many current needs assessment methodologies use interval-level scoring systems as thresholds for service eligibility. The Panel expressed some reservations about this method. Similar concerns are reflected by Williams:

With regard to the usefulness, or not, of scores to summate results of assessment items, in my view each individual bit of information obtained in the assessment procedure is likely to have specific value in designing the care plan for that particular patient. Adding up scores on numbers of disabilities, numbers of wrong (or right) answers on mental status tests, etc., is much like taking the results of multichannel clinical chemistry laboratory testing and saying that it is useful enough to know that only one, or two, or three of the tests are outside normal limits-that the precise details of which tests are abnormal, and by how much, is not necessary for clinical decisions. In other words, I am skeptical of the value of summarizing scores (1983, p. 640).

---

## Process concerns

The development of a needs assessment methodology for eligibility determinations also requires the formulation of a process by which assessments would be conducted. Pegels (1988) summarizes several policy concerns that would have to be addressed if a uniform system of needs assessment were established for eligibility determination:

- o Inherent to the concept of needs assessment is the fact that care needs may change over time. Therefore, the screening process must be continuous, including periodic review to ensure that the patient is receiving the care prescribed in the most suitable service setting; and
- o Those affiliated with providing services might be biased in their judgments. To ensure proper patient assessment, health care coordination and placement, it is important that the process be controlled by an unbiased organization. Patient assessment has generally been limited to the activities of hospital discharge units that determine the need for continued institutionalization or discharge to a home environment where home or day care can be provided. Similarly, if the person responsible for assessment and placement is affiliated with a long-term facility, that affiliation may influence the decision in the direction of institutionalization.

## I. RECOMMENDATIONS FOR 'FURTHER STUDY

Use of the UNAI in the current Medicare eligibility determination process is limited. However, the UNAI may have utility to supplement the current Medicare eligibility determination process or could play a primary role in determining eligibility for other long-term care programs.

However, the Panel urged caution in making decisions regarding the use of the UNAI for eligibility determinations. The Panel strongly believed that extensive testing should be conducted to ensure the reliability and validity of the UNAI before policy decisions are made regarding its use.

If the UNAI is eventually linked to eligibility determinations, the Panel believed that several issues should be addressed and policies developed to ensure fair and consistent determinations of eligibility for services. Policy decisions would need to be made regarding the process by which the assessment would be performed and whether an independent agency would be required to conduct the assessment, as opposed to making the needs assessment a clinical function performed by the originating provider (i.e., responsible for the discharge plan) or the receiving provider (i.e., responsible for provision of appropriate and necessary post-hospital services). If assessment results generated by the provider were to be used as the basis for eligibility determinations, it would be necessary to develop

---

procedures and implement systems to audit the accuracy of assessment findings as well as generate processes to adjudicate disparate findings.

The Panel strongly believed that continued study is necessary before the UNAI can be considered for potential use in eligibility determinations. If UNAI results are to be used as the basis of determining whether post-hospital services should be provided to Medicare beneficiaries, careful attention must be given to the development of clinical algorithms on which to make decisions regarding appropriate and necessary care. This would require the analysis of large data bases to determine appropriate care practices based on an individual's characteristics, care needs and unique situation.

It is possible that such study will occur as part of the Department's effectiveness initiative. As authorized by the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), the Agency for Health Care Policy and Research (AHCPR) has primary responsibility for establishing an effectiveness and outcomes research program for preventive, diagnostic and treatment strategies. AHCPR's Medical Treatment Effectiveness Program (MEDTEP) is focused on "improving the effectiveness and appropriateness of health care services through better understanding of the effects of health care practices on patient outcomes" (AHCPR Program Note, January 1990). This activity will be undertaken in conjunction with other components of the Public Health Service and HCFA.

AHCPR is also charged with expanding the databases available for health care research and improving the linkages among them. An early AHCPR bulletin announced that emphasis will be placed on improving Medicare databases and their linkages to other patient-centered databases (1990).

Use of a uniform system of needs assessment in the determination of eligibility for long-term care services holds much promise. However, much work is necessary to compile sufficient databases of patient-centered characteristics on which to base analyses and to refine the technology necessary to develop a clinically valid system. The following chapter summarizes the recommendations of the Panel and closes with directions for future study.

---

## References

The Advisory Panel on the Development of Uniform Needs Assessment Instrument(s): Verbatim transcript of the first meeting. Washington, D.C.: June 1-2, 1988.

Agency for Health Care Policy and Research (AHCPR). AHCPR program note. Rockville, Maryland: AHCPR, January 1990.

Brubaker, T. The long-term care triad: The elderly, their families and bureaucracies. In T.H. Brubaker (Ed.): Aging, Health and Family: Long-term care. Beverly Hills, California: Sage Publications, Inc., 1987.

Burke, T. Long-term care: The public role and private initiatives. Health Care Financing Review, 1988 Annual Supplement, 1-5.

Cohn, J. Cancelling catastrophic health. Government Executive, December 1989, 34-37.

Evashwick, C. & Weiss, L. The remaining questions. In C. Evashwick & L. Weiss (Eds.), Managing the continuum of care. Rockville, Maryland: Aspen Publishers, Inc., 1987.

Foley, W. & Schneider, D. A comparison of the level-of-care predictions of six long-term care patient assessment systems. American Journal of Public Health, 1980, 70.

General Accounting Office. The elderly should benefit from expanded home health care but increasing these services will not insure cost reductions. Washington, D.C., December 1982.

Grimaldi, P. & Jazwiecki, T. Case-mix payment systems for nursing home care. Chicago: Pluribus Press, 1987.

Gustafson, D., et al. Assessment of level of care: Implications of inter-rater reliability on health policy. Health Care Financing Review, Winter 1984, 6 (2), 50.

Institute of Medicine, National Academy of Sciences. A policy statement-the elderly and functional dependency. Washington, D.C.: National Academy of Sciences, June 1977.

Kane, R. & Kane, R. Assessing the elderly: A practical guide to measurement. Lexington, Massachusetts: Lexington Books, D.C. Heath and Company, 1981.

Neu, C. & Harrison, S. Prospective payment for Medicare post-hospital services: Some empirical considerations. Prepared for the Health Care Financing Administration, U.S. Department of Health and Human Services. Santa Monica, California: RAND/UCLA Center for Health Care Financing Policy Research, 1986.

Pegels, C. Health care and the older citizen: Economic, demographic and financial aspects. Rockville, Maryland: Aspen Publishers, Inc., 1988.

Providing for reconciliation pursuant to section 2 of the concurrent resolution on the budget for fiscal year 1987. Conference report to accompany H.R. 5300. House of Representatives, 99th Congress, 2nd Session, Report 99-1012. October 17, 1986. Washington, D.C.: U.S. Government Printing Office.

Rubenstein, L. The clinical effectiveness of multidimensional geriatric assessment. NIA Conference on Assessment. Reprinted from the Journal of the American Geriatrics Society, November and December 1983, 31 (11, 12), 758-765.

Somers, A. Financing long-term care for the elderly. In America's Aging: Health in an Older Society, Committee on an Aging Society: Institute of Medicine and National Research Council. Washington, D.C.: National Academy Press, 1985.

---

Task Force on Long-Term Health Care Policies.  
Report to Congress and the Secretary. Washing-  
ton, D.C.: United States Department of Health  
and Human Services. September 21, 1987.

United States Department of Health and Human  
Services, Health Care Financing Administration.  
The Medicare Handbook. Publication No. HCFA  
10050, 1989.

United States Department of Health and Human  
Services, Health Care Financing Administration.  
Medicare: Home Health Agency Manual. HCFA-  
Pub. 11, ICN 403750. March 1983.

United States Department of Health and Human  
Services, Health Care Financing Administration.  
Medicare: Skilled Nursing Facility Manual.  
HCFA-Pub. 12. June 1982.

Williams, M. & Williams, T. Clinical confer-  
ence: Assessment of the elderly for long-term  
care. Journal of the American Geriatrics Society.  
1982, 30, 71.

Williams, T. Comprehensive functional assess-  
ment: An overview. NIA conference on assess-  
Reprinted from the Journal of the Ameri-  
can Geriatrics Society, November and December  
1983, 31 (11,12), 637-641.

Williams, T., Hill, J., Fairbank, M. et al. Appro-  
priate placement of the chronically ill and  
aged: A successful approach by evaluation.  
Journal of the American Medical Association.  
1973, 226, 1332.



---

## CHAPTER 8: SUMMARY AND RECOMMENDATIONS FOR FURTHER STUDY

This report has examined issues related to the Congressionally mandated uniform needs assessment initiative and presented the recommendations of the Secretary's advisory panel, as required by Section 9305(h) of the 1986 Omnibus Budget Reconciliation Act (OBRA '86).

The Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) developed one needs assessment instrument (UNAI) for uniform use in various care settings. The enabling legislation specified that the instrument should be capable of use by "discharge planners, hospitals, nursing facilities, other health care providers and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services and long-term care services of a health-related or supportive nature." As required, the core of the UNAI focuses on the assessment of an individual's functional capacity, nursing and other care requirements, and social and familial supports. The UNAI also includes measures of health status, environmental factors, and patient/family goals and preferences for care. This range of assessment items is intended to provide holistic data on which to base the identification of options for continuing care and facilitate development of the actual discharge plan.

OBRA '86 did not contain a directive for use of the UNAI by the providers specified in the legislation but it did require the study of issues associated with its use. As such, the Panel also contemplated the context in which a uniform system for needs assessment could occur. Pro-

cess considerations; ranging from general instructions for completion of individual assessments to broader implementation or systems issues, were specified through the development of 26 recommendations regarding the use of the instrument. These recommendations address themes such as the purpose of the instrument, qualifications needed by the assessor, training and uniform use of the instrument, process for performing the assessment, timing of the assessment, resources necessary to administer the instrument, population to which the instrument should be administered, use of the instrument in non-acute care settings, coordination of data elements, mechanisms to ensure accountability for performance and the reliability of the assessment, and testing and evaluation.

Additionally, this report has reflected the Panel's deliberations regarding potential uses of the instrument. The UNAI was developed for the primary purpose of clinical assessment and decision-making regarding post-hospital and other long-term care needs. However, the UNAI could be used for other purposes, including quality assurance, generation of a data base and determination of an individual's eligibility for Medicare covered services.

### A. ADVANTAGES ASSOCIATED WITH UNIFORM USE OF THE UNAI

Federal regulations currently address the provider's responsibility to conduct a needs assessment as part of the discharge planning pro-

---

cess. Though specific programs vary in terms of the scope and language used to describe discharge planning expectations, similar requirements are in effect, or in the process of being implemented, for hospitals, home health agencies and long term care facilities. In effect, completion of a needs assessment is already required. Mandating use of the UNAI would add structure and process standards to the currently undefined, general requirement for the performance of a needs assessment by a provider prior to a beneficiary's discharge from that setting.

Certainly there would be some difficulties to address if a uniform system of needs assessment were to be implemented. Realistically, full implementation would probably require a period of several years. However, the Panel believed that the long-term advantages to both beneficiaries and providers would outweigh the start-up concerns associated with operationalization of the system.

### **Advantages for providers**

Uniform use of the UNAI would benefit providers by providing a comprehensive structure for completion of the needs assessment portion of their discharge planning responsibilities. Use of the UNAI by all providers would also provide a means to enhance continuity of care

and communication of patients' needs across care settings, by drawing upon a common methodology and language to evaluate extended care needs.

Though some providers maintain they require flexibility in their "needs assessment" methodology, many others are increasingly in favor of a standardized approach. A large number of acute care providers have expressed their intent to use the UNAI to implement a formal needs assessment system within their own facilities, recognizing the value of such a system to patient care. Anecdotally, numerous providers of post-hospital services have also been supportive of the UNAI and called for a system that facilitates the identification of appropriate post-hospital services, improves communication across care settings and the transfer of patient information regarding continuing care needs, and fosters continuity of care.

Several States have already developed "needs assessment" instruments but many others are in the process of developing their own instruments to assess needs for continuing care. The intended use of these instruments varies.<sup>1</sup> States that are currently developing or contemplating revision of their own instruments have looked to the Federal uniform needs assessment initiative for direction in terms of assessment content; most States have expressed an interest or their intent to

---

<sup>1</sup>A large number of States already use or are in the process of developing "needs assessment" instruments for purposes such as case management for Medicaid 2176 home and community-based services waiver programs,

Medicaid nursing home pre-admission screening, and assessment of the need for services administered by Agency on Aging programs.

---

build instruments with the same core elements used in the UNAI.<sup>2</sup>

The purpose of the assessment must drive its content (R. Kane, Panel presentation, August 3, 1988) and States will always require the flexibility to develop assessment methodologies that are appropriate for their own regulatory needs. However, implementation of a system of needs assessment at the Federal level would ensure a level of uniformity among the States. States could supplement the UNAI by adding assessment items to meet their own needs, provided the integrity of the UNAI remained intact.<sup>3</sup> Such standardization of needs assessment data would also be advantageous to providers, who must remain abreast of diverse requirements and document duplicative assessment data in some cases.

### **Advantages for beneficiaries**

Implementation of a uniform system of needs assessment should yield numerous patient care benefits. Requiring use of the UNAI would ensure that the continuing care needs of Medicare beneficiaries are appropriately evaluated. The UNAI would, in effect, be viewed as a clinical

standard to secure a consistent level of assessment. The UNAI provides a comprehensive and holistic assessment upon which to identify care needs and develop a discharge plan.

Additionally, most individuals with chronic needs receive care by a number of providers or in numerous settings, being transferred from one level of care to another as their condition improves or deteriorates. Transfer across several care settings or uncoordinated care provided simultaneously by a number of providers increases the potential for miscommunication and fragmentation of service delivery, leading to frustration and poor outcomes for the patient. Participation in duplicative and overlapping “needs assessments” can also be a bewildering and tiring experience for patients and families. By providing a common language and structure to facilitate the communication of care needs, the UNAI would have a positive impact on the totality of the beneficiary’s care experience over time.

The UNAI also has the potential to improve the quality and appropriateness of care in an ongoing manner. Congress required the development of a, needs assessment instrument(s) capable of use along the continuum of

---

<sup>2</sup>UNAI core elements are those that measure functional status, nursing and other care requirements, and social and familial supports:

<sup>3</sup>HCFA’s Long Term Care Facility Resident Assessment initiative operates on a similar premise. States are required to specify a Resident Assessment Instrument for use by Title XVIII and Title XIX long term care facilities

within the State. The State may specify the Resident Assessment Instrument that has been designated by HCFA or specify its own, provided it is approved by HCFA. For approval, a State instrument must contain at least the Minimum Data Set (MDS), including common definitions, core elements and utilization guidelines. The State may add additional items that support its own operational programs (e.g., for quality assurance, quality incentive, pre-admission screening, or case-mix reimbursement systems), provided they are not in conflict with the MDS.

---

various health care settings. The UNAI could be used prior to discharge<sup>4</sup> from each provider type to assess needs and ensure that continuing care recommendations are appropriate and address all necessary services.<sup>5</sup> In this manner, the possibility of premature discharge should be minimized as well as ensure that beneficiaries receive care in the least restrictive environment possible.

The Panel's recommendations also provide a structure for patient/family input by assessing the individual's and family/caregiver's goals and preferences for care. The Panel called for an patient attestation process to accompany administration of the UNAI in order to ensure an appropriate level of patient participation in the needs assessment. Administration of the UNAI as intended by the Panel would therefore heighten the beneficiary's opportunities to have input into the discharge planning process.

### **Additional advantages**

Clearly uniform use of the UNAI has the potential to improve the quality of care provided to Medicare recipients. In addition, the Panel felt there would be many secondary gains should use of the UNAI be required, ranging from advances in Federal quality assurance activities<sup>6</sup> to the development of a large-scale functional/social data base well beyond the capabilities of current systems. A UNAI-derived data base could be used for numerous purposes, including quality monitoring, research and health policy formulation.

## **B. RECOMMENDATIONS FOR FURTHER STUDY**

Though supportive of the need to move forward with the uniform needs assessment concept, the Panel felt that a Congressional mandate for

---

<sup>4</sup>In a case management system, beneficiaries' needs could be evaluated periodically using the UNAI. For example, a patient with a mild degree of functional impairment may be assessed as requiring chore service to assist with housekeeping and laundry. Reassessment in six months may indicate improvement in status (patient no longer requires chore service) or deterioration (patient no longer able to remain in the home safely with only chore assistance).

The value of periodic reassessment was demonstrated in a recent study that examined the use of a housing counselor specialist to follow-up with patients two months after hospital discharge. Reassessment and intervention by the counselor resulted in significant differences in the level of housing and support needed eight weeks after discharge. Such a process could lead to more appropriate, less costly service options (Aldridge, 1990).

<sup>5</sup>The potential impact of the UNAI falls short of ensuring that patients actually receive necessary posthospital services. The UNAI can be used only to identify patient needs, which serves as the basis for recommendations regarding necessary services. The actual discharge plan is dependent upon several factors, which include patient/family preferences, the availability of services and resource considerations (such as eligibility for public programs or third party reimbursement, ability to self-pay and the presence of informal support).

<sup>6</sup>The Panel studied the potential use of the UNAI in several Federal quality assurance activities, including Survey and Certification, Peer Review Organization (PRO) review and the Department's effectiveness initiative.

---

uniform use of the UNAI by various providers may be premature without first considering a number of issues. The Panel urged that decisions regarding implementation be deferred, pending a thorough evaluation of the instrument's effectiveness. Previously, the Panel discussed the need for additional study of several operational concerns associated with implementation, including the allocation of necessary resources, the need for a degree of flexibility to accommodate variations in care settings and delivery systems, and the duplicative requirements that currently exist for reporting of patient information.

At this point, the Panel believed that a number of steps should be pursued to provide the groundwork necessary to implement a uniform system of needs assessment.

### **Field testing**

The Panel outlined detailed recommendations regarding evaluation of the UNAI. A period of informal review and comment to establish content validity was conducted during the instrument development process, using a draft version of the UNAI. Comments from the field were then incorporated to produce the instrument that appears in this report. Should use of the UNAI be proposed as part of the Conditions of Participation for Medicare, additional opportunities for public comment would be provided through publication of the UNAI in the Federal Register.

At this point, pilot testing of the UNAI should be the next evaluation phase. The Panel recom-

mended that field testing occur prior to a directive from the Congress to require use of the UNAI. The design for field testing should include an evaluation of its use by a stratified sample of providers (i.e., at least hospitals, long term care facilities and home health agencies, as specified in the enabling legislation). If funding allows, the sample should be diverse and stratified according to variables such as geographic location, size, type of ownership, specialty status, rural/inner city, etc.

Modification of the UNAI may be necessary, depending upon the results of field testing. The Panel felt that the Secretary may find it valuable to continue consultation with experts in the field during the UNAI refinement process. Panel members offer-red to serve as an ongoing resource in providing consultation as needed.

If there is a decision to require use of the UNAI by Medicare participating providers, there should also be a long-range evaluation of its efficacy and impact on patient care and beneficiary outcomes after implementation of the uniform system of needs assessment.

### **Development of a uniform system of assessor training**

Supplementary materials should be developed to ensure that assessors use the UNAI in an appropriate manner. It would be necessary to prepare some instructional materials for assessors in order to field test the UNAI. One component of the field test should evaluate the adequacy

---

of assessor training (i.e., address the scope of the materials and degree of training necessary to ensure consistent administration of the instrument). Additionally, should use of the UNAI be required, it would be necessary to develop and disseminate additional instructional materials, as well as design a system for training of all potential users of the UNAI.<sup>7</sup>

### **Coordination with other Federal initiatives**

If use of the UNAI becomes a Federal requirement, the Panel felt it would be imperative to integrate the UNAI with other Federal requirements and forms. Where possible, efforts should be directed towards consolidation of documentation requirements to decrease the burden on providers. In other cases, differences in the purpose of assessment processes and forms may prohibit consolidation. However, to the extent possible, the terminology and approaches used in patient data bases and assessment-related initiatives should be compatible. To decrease unnecessary duplication and facilitate the provision of patient care, the data collected to meet one requirement should be capable of satisfying, at least in part, other requirements. Ideally, through a process of continued refinement and integration of various initiatives, the components of various require-

ments should be streamlined and interwoven to form a comprehensive data system.

### **Development of a uniform screening process**

In identifying the population that should be assessed by the UNAI, the Panel drew upon the framework used in the OBRA '86 requirement for discharge planning as a Condition of Participation for hospitals.<sup>8</sup> The Panel recommended that the UNAI be administered to those individuals who are identified through a screening process as needing a more intensive evaluation of their needs for continuing care. The Panel felt that requiring use of the UNAI for all Medicare beneficiaries was not clinically warranted and would waste scarce resources.

Should a uniform system of needs assessment based upon the recommendations of the Panel be introduced, there would be uniformity in the needs assessment process itself. However, the needs assessment requirement would apply to only a subset of Medicare beneficiaries. Neither the Conditions of Participation nor the Panel's recommendations specify requirements for the screening process that would affect all Medicare patients.

Previously, it has not been feasible to devise a universal screening process and criteria.

---

<sup>7</sup>For example, HCFA may assume responsibility for the development of training materials such as a user's manual and video tapes, with providers assigned responsibility for training their staff members who would perform the assessment. A similar system is currently being implemented as part of HCFA's Long Term Care Facility Resident Assessment initiative.

<sup>8</sup>The Condition of Participation requires hospitals to identify all Medicare patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. These patients are required to receive a discharge planning evaluation.

---

According to a review of the literature and experts in the field, screening systems and criteria should be tailored according to the needs and case-mix of individual facilities. However, it is obvious that a uniform system of needs assessment is of questionable value if there is no safeguard to ensure that patients are appropriately screened and targeted to receive the assessment. For this reason, the Panel recommended that additional study be given to the refinement of screening mechanisms to identify patients in need of additional discharge planning services. The Panel believed that providers require a certain amount of flexibility in developing their own screening methodologies but felt that there should be some level of uniformity in the screening process.

Screening systems used by hospitals often use criteria such as diagnosis (e.g., CVA, cancer), age (i.e., greater than 70), and source of admission (i.e., from a nursing home) to identify patients in need of a more intensive discharge planning evaluation. Studies supporting the efficacy of such factors have been limited in number and inconclusive in terms of their findings. One interesting approach may be to require a scaled-

down evaluation of critical UNAI factors for all patients, as part of the screening process to identify “high risk” patients (Nonemaker & Rudman, unpublished paper). For example, simple indicators to assess possible problems regarding functional status or lack of social support could be used to identify patients who should receive a more intensive evaluation (i.e., trigger administration of the UNAI.)<sup>9</sup>

### **Use of the UNAI for eligibility determinations**

One of the driving forces behind the Congressionally mandated uniform needs assessment initiative was the desire to establish a more objective and clinically focused system of determining eligibility for long term care services. The Panel supported the goal of a health care delivery system that provides “care based on need rather than on what the individual is eligible for” but did not feel that the UNAI could play a primary role in the current process of determining eligibility for Medicare covered post-hospital services.

The Panel’s extensive review of the literature corroborated that clinical decision-making regarding an individual’s needs for post-hospital

---

<sup>9</sup>A recent study examined a patient characteristic model that may be helpful to providers in identifying patients who require formal posthospital services. Buckle (1990) used two instruments to assess 1300 “high-risk” patients in terms of severity to predict their use of posthospital resources: the medically-oriented Computerized Severity Index and Complexity Factors (a tool consisting of five functional/socially oriented factors rated on a four point scale: Social Situation, Physical Functioning, Psychological Functioning, Compliance and Communication).

Items related to ADLs, Communication and Psychological Functioning consistently performed as statistically significant predictors of the use of formal posthospital services. Social Situation was not found to be an important predictor of the use of formal posthospital services. However, this finding was inconclusive and raises additional questions regarding the assessment and documentation practices of physicians, nurses and social workers as it relates to the social situation of patients: **there was very little documentation about social situation** in the medical records of the study population (previously defined as high-risk elderly).

---

and other extended care services revolves around an assessment of functional status, nursing and other care needs and the availability of family and community support, the three components of the Congressional charge. Clearly it would be advantageous to design measures to establish eligibility for long-term care services based on a clinical algorithm that determines appropriate and necessary services by weighing a beneficiary's strengths, weaknesses and individual needs.

Several pieces of legislation were introduced in the 100th Congress that would have expanded the coverage of long-term care services under Federally financed programs. All of the long-term care bills used limitations in functional status, as measured by activities of daily living, as a criterion to establish eligibility. Most of the bills drew on a uniform assessment process performed by a case-manager to promote the coordination of care and contain costs (Mittelstadt, 1988; Seklecki, 1989). Though budgetary constraints may have sidelined the issue, Congressional interest in a functional/social model on which to determine eligibility for long-term care benefits will no doubt resurface in the future.

The Panel felt strongly that decisions on eligibility policy should be based on outcomes research. Beneficiary-centered, clinical data is necessary to support analyses regarding appropriate and necessary post-hospital care. The Panel advocated implementation of a uniform system of needs assessment to allow the compilation of a data base for such studies. This

philosophy is consonant with that of the Department's effectiveness initiative and is the focus of current efforts by the Agency for Health Care Policy and Research, other components of the Public Health Service and HCFA.

However, the Panel also believed that future reforms of the eligibility determination process should foster individual self-determination, rather than artificially restrict options to meet continuing care needs through the establishment of overly stringent medical necessity criteria. Panel members were concerned that a rating system may be developed that would assess an individual and determine that he or she was eligible for only one particular type of care when there may be several options that are clinically valid and equally efficacious.

Rather, beneficiary needs could be rated uniformly through the use of a needs assessment process but the decision-making process should allow the beneficiary to choose among appropriate and effective options to meet continuing care needs. Such a process would maximize independence by allowing individuals appropriate support in the least restrictive environment possible as well as promote the most efficient use of resources.

## C. CONCLUSIONS

Congressional concerns regarding quality and access to necessary post-hospital services fueled the development of the uniform needs assessment instrument. The dramatic changes in length



---

of stay and practice patterns brought about through the Medicare Prospective Payment System have become commonplace; clinicians routinely provide care for an older and more debilitated patient population. Patients are “sicker” and discharged “quicker,” but providers have an inherent responsibility to assess and provide for a beneficiary’s needs for continuing care.

The specter of limited resources continues to drive the health care delivery system on a broader level as well as affect individual patient encounters through the system. Limitations in funding for health care are the reality of today and a growing problem for tomorrow, as society struggles with how to address growing needs for long-term care services. Financing mechanisms will continue to shift health care delivery to non-acute levels of care and outpatient settings. It is paramount, then, that necessary safeguards to

ensure quality and access to necessary post-hospital services are built into the system. A uniform system for needs assessment holds promise as a means to ensure that continuing care needs are evaluated and provided for in the most appropriate manner.

The Panel urges the reader to view the sum of its recommendations collectively as reflecting the primary goal that shaped its work process. This goal was to achieve a critical balance between quality of care and operational concerns: to develop an instrument that would improve post-hospital care by providing a thorough and valid evaluation of continuing care needs, and also be capable of use across diverse care settings, thereby providing uniformity in the assessment of post-hospital needs. In time, the UNAI will demonstrate its utility in both respects.

---

## References

Aldridge, S. Counselor intervention enhances life, reduces costs. Discharge Planning Update, March/April 1990, 10 (2), 3-7.

Buckle, J. Predicting post-hospital resource use with severity. (Doctoral dissertation, The Johns Hopkins University School of Hygiene and Public Health, 1990).

Mittelstadt, P. Congress to focus on long-term care. The American Nurse, December 1988, 20 (12).

Nonemaker, S. & Rudman, J. High-risk screening:: The next generation. Unpublished paper presented at the 11 th Annual Discharge Planning Symposium of the American Hospital Association's Society for Hospital Social Work Directors, October 1990.

Seklecki, M. Long-term care issue on the horizon. Discharge Planning: Update, January/February 1989, 14-16.

**REPORT OF THE SECRETARY'S ADVISORY PANEL  
ON THE DEVELOPMENT OF  
UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)**

**APPENDICES**



## **APPENDIX A**

**Enabling Legislation**

**Advisory Panel Charter**



OMNIBUS BUDGET RECONCILIATION ACT OF 1986

SEC. 9305

*(h) DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT.—*

*(1) DEVELOPMENT.—The Secretary of Health and Human Services shall develop a uniform needs assessment instrument that—*

*(A) evaluates—*

*(i) the functional capacity of an individual.*

*(ii) the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities; and*

*(iii) the social and familial resources available to the individual to meet those requirements; and*

*(B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health-related or supportive nature.*

*The Secretary may develop more than one such instrument for use in different situations.*

*(2) ADVISORY PANEL.—The Secretary shall develop any instrument in consultation with an advisory panel, appointed by the Secretary, that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries.*

*(3) REPORT ON INSTRUMENT.—The Secretary shall report to Congress, not later than January 1, 1989, on the instrument or instruments developed under this section. The report shall make recommendations for the appropriate use of such instrument or instruments.*



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

CHARTER

ADVISORY PANEL-ON THE DEVELOPMENT OF UNIFORM  
NEEDS ASSESSMENT INSTRUMENT(S)

PURPOSE

The Advisory Panel on the Development of a Uniform Needs Assessment Instrument(s) (hereinafter referred to as the "Advisory Panel") directed by Congress in the Omnibus Budget Reconciliation Act of 1986, will provide consultation to the Secretary in developing any instrument(s) to evaluate an individual's need for post-hospital extended care services, home health services, and long-term care services of a health-related or supportive nature. The needs assessment instrument(s) shall evaluate the functional capacity of an individual, the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and the social and familial resources available to the individual. The functional capacity of an individual should include a description of the individual's diagnosis and an evaluation of the constraints on the individual's ability to engage in activities of daily living. The instrument(s) could be used by discharge planners, hospitals, nursing facilities, other health care providers and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services.

AUTHORITY

42 U.S. Code 1395x note, Section 9305(h)(2) of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509).

The Advisory Panel is governed by the provisions of Public Law 92-463 (5 U.S. Code Appendix 2), which sets forth standards for the formation and use of advisory committees.

FUNCTION

The Advisory Panel must report to the Secretary of Health and Human Services and to the Administrator of the Health Care Financing Administration (HCFA) on the instrument(s) developed.

The Advisory Panel shall provide consultation to the Secretary in developing a uniform needs assessment instrument(s) that--

(A) evaluates--

- (i) the functional capacity of an individual,
- (ii) the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and
- (iii) the social and familial resources available to the individual to meet those requirements; and



- (B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health-related or supportive nature.

#### STRUCTURE

The Advisory Panel shall consist of 18 members including the Chair. Members shall be selected by the Secretary and shall include experts in the delivery of post-hospital extended care services, home health services and long-term care services and shall include representatives of hospitals, physicians, skilled nursing facilities, home health agencies, long-term care providers, fiscal intermediaries, Medicare beneficiaries, and Federal agencies with responsibilities relating to discharge planning.

Members shall be invited to serve for the life of the Advisory Panel. A vacancy on the Advisory Panel shall be filled in the manner in which the original appointment was made.

Management and support services shall be provided by the Health Standards and Quality Bureau, Health Care Financing Administration.

#### MEETINGS

Meetings shall be held approximately three times per year at the call of the Chair with the advance approval of a Government official, who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings shall be open to the public except as determined otherwise by the Secretary; notice of all meetings shall be given to the public.

Meetings shall be conducted, and records of the proceedings kept, as required by applicable laws and Departmental regulations.

#### COMPENSATION

Members who are not full-time Federal employees shall be paid at the rate of \$100 per day, plus per diem and travel expenses, in accordance with Standard Government Travel Regulations.

#### ANNUAL COST ESTIMATE

Estimated annual cost for operating the Advisory Panel, including compensation and travel expenses for members, but excluding staff support is \$156,632. Estimate Of annual man years of staff support required is 4.0, at an estimated annual cost of \$214,171.

REPORTS

The Advisory Panel shall report to the Secretary in time to permit the Secretary to issue a final report to the Congress by January 1, 1989.

The final report shall:

1. describe the instrument(s) developed; and
2. make recommendations for the appropriate use of the instrument(s), including and evaluation of the advantages and disadvantages of using the instrument(s) as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to Medicare beneficiaries.

TERMINATION DATE

The Advisory Panel shall terminate 90 days after the date of submission of the Secretary's final report to Congress.

APPROVED:

MAY 4 1987

Date



\_\_\_\_\_  
Otis R. Bowen, M.D.  
Secretary

## **APPENDIX B**

### **Advisory Panel Members**



ADVISORY PANEL ON THE DEVELOPMENT OF  
UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

<u>Category</u>	<u>Panel Member</u>	<u>Nominating Organization</u>
Two members representing hospitals	Jay C. Rudman, M.S.W., M.P.A. Margaret D. <b>Sovie</b> , Ph.D., R.N.	American Hospital Association and National Association of Social Workers American Nurses' Association and National League for Nursing
Two members representing physicians	Dennis W. Jahnigen, M.D. <b>Phillip</b> M. Smith, M.D.	American Medical Association National Medical Association
Two members representing skilled nursing facilities	Mary T. Knapp, R.N., M.S.N. William H. Thorns, B.A.	National League for Nursing and American Nurses' Association Department of Health and Human Services
Two members representing home health agencies	Donna A. Peters, Ph.D., R.N. Elaine R. Williams, A.C.S.W.	National Association for Home Care National Association of Social Workers
Two members representing long-term hospital care	Stephen K. Forer, M.A. Gabe J. Maletta, Ph.D., M.D.	National Association of Rehabilitation Facilities American Psychiatric Association
Three members representing post-hospital care services	Benjamin Shimberg, Ph.D. Agnes C. <b>McBroom</b> , R.N., B.S.N. Marcia A. Orsolits, Ph.D., R.N.	American Psychological Association American Association for Continuity of Care Ernst & Whinney
One <b>member representing</b> fiscal intermediaries	James C. Sisk, M.D.	Blue Cross and Blue Shield Association
Two members representing Medicare beneficiaries	Victor Hurst, Ph.D. Lucia <b>DiVenere</b> , M.A.	American Association of Retired Persons National Council of Senior Citizens
Two members selected at the discretion of the Agency	Constance McGregor, R.N., B.S.N. Barbara Schneider, B.S.N., M.A.	Department of Health and Human Services Department of Health and Human Services

**ADVISORY PANEL ON THE DEVELOPMENT OF  
UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)**

ADVISORYPANELBICGRAPHIES

CHAIRMAN

Jay C. Rudman

Mr. **Rudman** is a hospital administrator and is presently Assistant Director of Support Services and Chief of Clinical Social Work at UCLA Medical Center. At the Medical Center, Mr. **Rudman's** responsibilities include the **Home** Care Program and Continuing Care Program. His interests stem from both a clinical involvement over the years in discharge planning and continuity of care issues, as well as his expertise in **management** and operational system. Mr. Rudman is a past president of the American Hospital Association's Society for Hospital Social Work Directors.

PANEL MEMBERS

Lucia DiVenere

**Ms.** DiVenere is presently Public Policy Advocate for the Villers Foundation in Washington, D.C. Formerly, she was Director of Legislation for the National Council of Senior Citizens.

Stephen K. Forer

Mr. Forer is currently the Rehabilitation Services Manager at Santa Clara Valley Medical Center in San Jose, California, where he is responsible for providing program direction, **coordination** and management of the **70-bed** Rehabilitation Center. His interests include management information systems, functional assessment, program evaluation **and** quality assurance. He is **co-**chairperson of the American Congress of Rehabilitation Medicine Task Force that developed the **Uniform** Data System for Medical Rehabilitation. He has given numerous professional and scientific presentations and has over 30 publications to his credit. Mr. Forer earned a master's degree in **Community/Clinical** Psychology **from Pepperdine** University and a Masters of Business Administration from National University.

Victor Hurst, Ph.D.

Dr. Hurst is a member of the **Board** of Directors of the American Association of Retired Persons. He received his doctorate from the University of Missouri in 1948 and is **member** of the **Sigma Xi** honorary society. His professional interests include epidemiology and physiology.

Dennis W. Jahniuen, M.D.

Dr. Jahnigen is the Head of Geriatric Medicine at the Cleveland Clinic Foundation in Cleveland, Ohio. He is a member of the American Medical Association and an expert in the field of geriatric medicine and research.

Mary T. Knapp

Mary Knapp is Vice President of John **Whitman** and Associates, Inc. Geriatric Health Care Consultants, Philadelphia, Pennsylvania. She is a certified gerontological nurse practitioner and licensed nursing **home administrator**. Ms. Knapp has extensive experience in caring for older adults in acute care and skilled nursing facility settings. She has been a two-term elected member of the Executive **Committee** of the American Nurses' Association's Council on Gerontological Nursing, is a current **member** of the Joint Cmmission on Accreditation of Healthcare Organizations' (JCAHO) Professional Technical Advisory **Committee** for **Long Term Care**, and has served on numerous national **committees** regarding post-acute care services for the elderly.

Gabe Maletta, Ph.D., M.D.

Dr. Maletta received his Ph.D. in physiology from the University of California at Berkeley and his M.D. from Case-Western Reserve University Medical School. A board certified psychiatrist, Dr. Maletta has authored over 65 publications regarding cognitive and psychiatric problems in the geriatric population. As the director of the Geriatric Research, Education and Clinical Center at the Veteran's Administration Medical Center in Minnesota, he has been **working** on a five-year grant from the National Institutes of Health to study **Alzheimer's** disease.

Agnes Celine McBroom

**Ms. McBroom** is currently the director of Patient and Family Services at Valley Presbyterian Hospital in Van Nuys, California. She has extensive knowledge of hospital discharge planning, having worked in the discharge planning field since 1965. **Ms. McBroom** is also a past president of the American Association for Continuity of Care.

Constance McGregor

Mrs. McGregor served on the Case Mix Advisory **Board** that instituted the RUGS II **Program** in New York. She also served as a special consultant to the Bureau of **Long Term Care**. Currently she is a Case Mix Nurse Reviewer for the Foundation for Quality Medical Care, Inc. She is also a **Community Liaison** for the New York State Senate.

Marcia A. Orsolits, Ph.D.

Dr. Orsolits is presently Director of Nursing Research at the Cleveland Clinic Foundation. Formerly, she was National Director of Nursing and Clinical Consulting Services for Ernst and **Whinney**. Dr. Orsolits has been developing uniform assessment tools since 1968 in the areas of psychiatry, patient classification and quality monitoring. She is also a faculty member of Case-Western Reserve University in Cleveland, Ohio.

Donna A. Peters, Ph.D.

Dr. Peters is currently project director for the **development** of home care quality monitors at the National League for Nursing. **Previously**, she was a program officer for the Robert Wood Johnson Foundation in Princeton, New Jersey. Dr. Peters has **an extensive background in home** healthcare and quality assurance and is active in many nursing professional organizations.

Barbara Schneider

**Ms.** Schneider is an expert in the field of case **management**. She holds a B.S. in nursing and an M.A. in health education. Currently, she is participating in an evaluation of the pre-admission assessment program in Pennsylvania and a pilot study regarding the **adequacy** of access to posthospital **home** care services for Medicare beneficiaries.

Benjamin Shimberg, Ph.D.

Dr. **Shimberg** is a Senior Research Scientist at Educational Testing Services in Princeton, New Jersey. He is an active member of the American Association for Retired Persons and contributes his time and expertise to many beneficiary advocacy concerns.

James C. Sisk, M.D.

Dr. Sisk received his B.A. and M.D. **from** Washington University in St. **Louis**. A **member** of both Phi **Beta** Kappa and Sigma Xi honorary societies, Dr. Sisk has served on several notable boards and **commissions** including the United Nations Palestine Ccmission (1948), the White House Fellowship Evaluation Ccmission (since 1986) and the Health Care Financing Ccmission of the St. **Louis** Medical Society.

Phillip M. Smith, M.D.

Dr. Smith is in the private practice of medicine, obstetrics and gynecology. Dr. Smith is a past president of the Rational Medical Association as well as a cmissioner for the Commission of Hospitals for the County of **Los** Angeles. He was actively involved in the **development** of the Martin Luther King Hospital in **Los** Angeles, California.



Margaret D. Sovie, Ph.D.

Dr. **Sovie** is the Associate Executive Director and Director of Nursing at the Hospital of the University of Pennsylvania and Associate Dean of the School of Nursing and Jane Delano Professor of Nursing Administration at the University of Pennsylvania School of Nursing. She is also a fellow in the American Academy of Nursing; **member** of the American Nurses Association's Cabinet on Nursing Services; and member of the Institute of Medicine and the Institute of Medicine's **Committee** on "A Strategy for Quality Assurance in Medicare."

William H. Thoms

Mr. Thoms is the Director of William H. **Thoms** Associates in New Ipswich, **New** Hampshire. Mr. Thoms is also the long-term care coordinator for the American Association for Retired Persons in New Hampshire. He was previously a nursing home administrator and has had much experience with resident assessment issues and case management.

Elaine R. Williams

**Ms.** William received a master's degree in social work from the University of Michigan. As the regional director of the Visiting Nurses Association of Metro Detroit, she has been actively involved in policy planning and legislative issues. In 1986, she conducted a national survey on problems associated with the delivery of home care social work services. Ms. Williams has authored several works related to Medicare and **home** health care issues.



## **APPENDIX C**

### **Meetings of the Secretary's Advisory Panel on the Development of Uniform Needs Assessment Instrument(s)**



**MEETINGS OF THE SECRETARY'S ADVISORY PANEL  
ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)**

June 1-2, 1988

Hyatt **Regency** on Capital Hill  
Washington, D.C.

Legislative History of the Uniform Needs Assessment Initiative:

David Schulke, Investigator  
Senate Special Cmmittee on Aging

**Beth Fuchs, Analyst**  
Congressional Research Office

Overview of Discharge Planning Concerns: The Importance of Discharge  
Planning in Ensuring Continuity of Care and the Appropriateness of  
After-Care:

Carrie Hatzis, Director, Social Work  
Fairfax Hospital

Overview of Functional Assessment Issues: The Application of a Uniform  
Data **System** in Evaluating Patient Care and **Outcomes--The Functional  
Independence Measure (FIM):**

**Byron** Hamilton, M.D., Ph.D.  
Clinical Associate Professor of  
Rehabilitation Medicine and Director  
of Data Management Service for the Uniform  
Data Set for Medical Rehabilitation, State  
University of **New** York at Buffalo

Case Study in Tool Development for Widespread Application. The New York  
Experience: **RUGS II and Care Croups Quality Assurance System:**

Don Schneider, Ph.D.  
Director, Health Systems Management Program  
Rensselaer Polytechnic Institute

August 3-4, 1988

**Sheraton Santa Barbara Hotel and Spa**  
Santa Barbara, California

Critical Elements in the Assessment of the Elderly and Overview of the University of Minnesota Post-Acute Care Study

Robert L. Kane, M.D.  
Dean, **School of Public Health**  
University of Minnesota

Presentations by Panel Members:

Overview of Functional Assessment Instruments

Stephen Forer

Behavioral and Cognitive Issues in Assessment

Gabe Maletta, Ph.D., M.D.

Measuring Family and Community Resources

Jay Rudman

Assuring Continuity and Patient/Family Self-Determination through Interdisciplinary Collaboration and Communication

Dennis Jahnigen, M.D.  
Elaine Williams  
Victor Hurst, Ph.D.

Assessment of Nursing and Other Care Considerations: Discharge Planning in Acute Care

Agnes McBroom

Assessment of the Need for Care: Skilled Nursing Facility and Supportive Care

Mary Knapp

Assessment of the Need for Care: Home Health Care

Donna Peters, Ph.D.

September 26-27, 1988

Sheraton **Towson** Conference Hotel  
**Towson**, Maryland

The Evaluation of a Uniform Needs Assessment Instrument:  
Theoretical and **Pragmatic** Criteria

M. Jo **Namerow**, Ph.D., President

**Namerow** and Associates

The Role of a Uniform Needs Assessment Instrument in the Discharge  
Planning Process

Judith Trachtenberg, Director, Social Work  
New York Hospital

Implications of a Uniform Needs Assessment Instrument for the  
**Interdisciplinary Team** Planning for **Discharge**

Pat Hanson, President  
Healthcare Management Services

Assessment **Instruments** Under Development for Use in Alternate Care  
Settings:

Long Term Care Facility Resident Assessment Instrument

Alan Friedlob, Chief, Nursing Homes **Branch**  
Office of Survey and Certification, Health Standards  
and Quality **Bureau**, Health Care Financing  
Administration

Home Health Functional Assessment Instrument

Sue Nonemaker, Program Analyst, Acute Care Services  
Branch, Office of Survey and Certification, Health  
Standards and Quality **Bureau**, Health Care Financing  
Administration

December 7-8, 1988

Marina International Hotel  
**Marina del** Rey, California

Implications Regarding the Use of a Uniform Needs Assessment Instrument  
for Monitoring the Appropriateness of Discharge Planning

Kenneth Kahn, M.D., Chairman, Continuing **Care Committee**  
American Medical Peer Review Association

Liability Concerns Associated with the Uniform Needs Assessment  
Instrument

Suzanne Mitchell, Staff Counsel, Hospital of the  
University of Pennsylvania



February 22-23, 1989

Hotel Intercontinental  
New Orleans, Louisiana

Use of a Uniform Needs Assessment Instrument to Determine Eligibility for Posthospital Services for Medicare Beneficiaries: Medicare Coverage Policy and the Role of Fiscal Intermediaries in Eligibility Determinations

Andrea Ringgold, Chief, Provider Medical Review Branch,  
Office of Program Operations and Procedures, Bureau of  
Program Operations, Health Care Financing  
Administration

Use of Pre-admission Tools by Providers to Predict Eligibility for Services

Vera Reublinger, Long Term Care Nurse Specialist  
American Health Care Association

Joyce Ollis, Director, Home Health  
Rapides General Hospital

Implications of a Uniform Needs Assessment Instrument for Eligibility Determinations by Third Party Payers

Sharon Mays  
United Mine Workers Health and Retirement Funds

Marilyn Cassell, Nurse Consultant Supervisor  
Aetna Life and Casualty

July 24-25, 1989

Washington Marriott  
Washington, D.C.

Report on Field Review and Comment Process

John Feather, Ph.D.  
Co-Director, Western New York Geriatric Education  
Center, State University of ~~New~~ York at Buffalo

## EXECUTIVE SUMMARY

### FIRST MEETING OF THE ADVISORY PANEL ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

June **1-2, 1988**

- o The first meeting of the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) was held June 1-2, 1988, at the Hyatt Regency in Washington, D.C. The Advisory Panel was established under the authority of Section 9305 of the Omnibus Budget Reconciliation Act of 1986, and charged with developing a standardized method to evaluate the **post-hospital** needs of patients.
- o Jay Rudman, M.S.W., M.P.A., Panel Chairman; outlined the Congressional mandate for the Panel members and the responsibilities of the Panel in fulfilling this mandate.
- o Beth Fuchs and David Schulke, staff members of the Senate Special Committee on Aging who had actively worked toward passage of the legislation as part of the Medicare Quality Protection Act, described the **environment** that shaped the legislation, the passage of the legislation, and the concerns of the Committee for the work of the Panel. Jay Rudman spoke to recent changes in the health care delivery system that had strengthened support for a uniform needs assessment instrument by the health care industry.
- o Panel members. introduced themselves, described their backgrounds and affiliations and stated their concerns regarding the development of the assessment tool: accuracy of patient description, provider and user needs, and potential sources for the Panel to consider in developing the assessment instrument.
- o Carolyn Hatzis, Director of Social Work at Fairfax Hospital in Falls Church, Virginia, outlined the discharge planning process and discussed several practical considerations in planning for the care of patients after hospitalization. She conveyed many of the interests and concerns of the hospital discharge planning community regarding the development of a uniform measure to assess patients' needs for care.
- o Bryon Hamilton, M.D., Ph.D., Clinical Associate Professor of Rehabilitation Medicine, SUNY, Buffalo, School of Medicine, addressed the Panel on issues related to the assessment of functional capabilities of patients. He described his work in developing the Functional Independence Measure (FIM), an instrument used to evaluate patient care and outcomes that is based on the Uniform Data System developed for use within the rehabilitation industry.

- 
- 0 Don Schneider, Ph.D., Director of the Health Systems Management Program at the Rensselaer Polytechnic Institute School of Management, provided an overview of RUGS II, a prospective payment case mix system developed for reimbursement of long-term care in New York State. He pointed out many of the difficulties encountered in designing an instrument for widespread application.
  - 0 Twenty-seven members of the public attended the meeting. Members of the public participated in question and answer sessions with the speakers and were given the opportunity to address the Panel. Alfred Chiplin of the National Senior Citizens' Law Center made a formal statement.
  - 0 Otis **Bowen**, M.D., Secretary of the Department of Health and Human Services, addressed the Panel members, thanking them for participating, and stressing the importance the Department places on ensuring a high level of care for the post-hospital needs of patients. The Secretary was accompanied by Glenn Hackbarth, Deputy Administrator of the Health Care Financing Administration.
  - 0 In Executive Session, the Panel discussed administrative details, summarized some of the issues raised by the Panel, speakers and members of the public, and drew up tentative agendas for the upcoming three meetings.

## EXECUTIVE SUMMARY

### SECOND MEETING OF THE ADVISORY PANEL ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

August 3-4, 1988

The second meeting of the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) was held August 3-4, 1988, at the Sheraton Santa Barbara Hotel and Spa, Santa Barbara, California. The focus of the meeting was to begin to establish the critical elements in a uniform needs assessment instrument to determine post-hospital care needs for Medicare beneficiaries.' The Panel heard presentations by members and an invited guest on various aspects of the discharge planning assessment.

- o Robert Kane, M.D., Dean, School of Public Health, University of Minnesota, discussed critical elements in the assessment of the elderly. He stated that assessment instruments are generally developed to define prognosis, chart progress or plan care, and stressed that the Panel must establish the primary purpose of the uniform needs assessment before developing the instrument. Factors he considered important to assess are the source of the patient's prior care, functional status, mental status, motivation, and expectations of the patient and family.
- o Dr. Kane also described the University of Minnesota's **Post-Acute Care Study**. The study examines variations in **post-hospital care careers** and identifies the factors that affect the type and **amount of** post-hospital care patients receive. The study also looks at the level of functioning and independence experienced by patients six months **post-hospitalization** to assess the relative effectiveness of alternative modalities for similar groups of patients.
- o Stephen Forer, M.A., presented an overview of functional assessment instruments. Functional status is generally defined and assessed as competence and independence in activities of daily living, mobility, communication and psychosocial adjustment. Mr. Forer discussed methodological and conceptual issues in constructing and using functional assessment instruments and illustrated these issues with sample instruments.
- o Gabe Maletta, Ph.D., M.D., addressed the Panel on behavioral and cognitive issues in the assessment of the geriatric population. He outlined many of the issues related to the definition and diagnosis of mental health problems found commonly in the elderly.
- o Jay Rudman, M.S.W., M.P.A., spoke on the topic of measuring family and community resources. He utilized the concept of membership to structure recommendations for the assessment of supports available to the patient and presented several

---

examples of instruments to measure social supports that are currently in use.

- 0 Dennis Jahnigen, M.D., acted as moderator for a discussion of the need to assure continuity and patient/family **self-**determination through interdisciplinary collaboration and communication. Dr. Jahnigen described a process used to individualize health **care** decisions that begins with an assessment of the patient's value system and objectives for care. Elaine Williams, A.C.S.W., discussed barriers that currently inhibit self-determination and interdisciplinary coordination and result in gaps or duplication of services. Victor Hurst, Ph.D., presented the perspective of the beneficiary and called for the inclusion of patient and family preferences and desires in the discharge planning assessment.
- 0 Agnes **McBroom**, R.N., B.S.N., detailed nursing and other care considerations assessed by the discharge planner in acute care. She categorized areas of assessment according to social, functional and clinical needs, and described numerous examples of items generally included in the assessment phase of discharge planning.
- 0 Mary Knapp, R.N., M.S.N., discussed the assessment of the need for care from the perspective of skilled nursing and supportive care. She outlined the various types of **post-**hospital care available to patients and identified factors that may indicate a need for such care.
- 0 Donna Peters, R.N., Ph.D., proposed that the characteristics and care needs of patients receiving home health care are so diverse that the goals of the patient and clinicians involved in discharge planning must be the driving force of the assessment. She presented a construct used to organize information regarding nursing care needs for the patient entering into the home health care system. The construct is based on a nursing model and collects information in the domains of environmental, psychosocial, physiological and health behaviors.
- 0 Correspondence received from the public was reviewed, and examples of numerous instruments developed to assess the needs of patients were presented.
- 0 Darrell Floyd, Manager, Human Resources, Planning and Staffing, University of California at Los Angeles Medical Center, led the Panel through a Nominal Group Technique exercise to identify critical elements for inclusion in a uniform needs assessment instrument. **Panel** members were asked to include measures of functional capacity, nursing and other care needs and family and community resources. A preliminary list of 105 items was developed; items were then clarified and Panel members were asked to prioritize items. The items receiving a priority ranking will be defined and criterion statements will be developed for review at a future meeting.

## EXECUTIVE SUMMARY

### THIRD MEETING OF THE ADVISORY PANEL ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

September 26-27, 1988

The third meeting of the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) was held September 26-27, 1988, at the Sheraton **Towson** Conference Hotel, **Towson**, Maryland. The focus of the meeting was to continue deliberations regarding the items to be included in a uniform needs assessment instrument to determine post-hospital care needs for Medicare beneficiaries and to address issues related to the implementation of the proposed instrument.

- o The Panel reviewed their progress to date and the plan to accomplish the remainder of their charge to develop recommendations for the Secretary of the Department of Health and Human Services.
- o Chairman Jay Rudman presented a framework for the assessment instrument that encompassed the categories and reflected the process used in clinical decision-making regarding posthospital **care needs**. The flow of the data to be collected under the proposed assessment was as follows: sociodemographics; health status; functional status; environment; social support; professional care needs; community services; and patient/family values and preferences.
- o The Panel reviewed preliminary content under the areas of physical and mental health status, functional assessment, social support and patient/family decision-making in terms of items for possible inclusion, suggested language and definition statements. Recommendations for continued work were made.
- o Members of the public were given the opportunity to comment on the Panel's preliminary work in establishing the instrument's content.
- o Deliberations shifted to issues surrounding operational concerns regarding the use of a uniform needs assessment instrument. Invited speakers addressed topics related to the implementation of a uniform needs assessment instrument.
- o M. Jo **Namerow**, R.N., Ph.D., outlined theoretical and pragmatic criteria to consider in evaluating an instrument for reliability and validity. Her presentation assisted the Panel in making recommendations for the evaluation of the proposed instrument that called for review by clinical experts and interested organizations/associations as well as field testing.

- 0 Methodological issues associated with the development of the instrument, such as, the measurement of variables, source of assessment data, and the timing of the assessment, were discussed.
- 0 Judith Trachtenberg, A.C.S.W., **discussed the** role of a uniform needs assessment instrument as a component of a larger discharge planning system. By sharing her experiences with similar State requirements and analyzing the impact of a uniform needs assessment instrument on institutions from an operational standpoint, she projected possible implications for the hospital industry should a uniform needs assessment instrument be mandated.
- 0 Patricia Hanson, R.N., spoke about the use of the proposed assessment instrument by the interdisciplinary team responsible for assessing continuing care needs. She stressed the need to develop an instrument that is concise and **user-**friendly. She advised the Panel to consider a means to incorporate data already being collected by professionals involved in direct care. This would minimize duplication of efforts and also insure that all patients receive necessary and appropriate discharge planning.
- 0 Alan **Friedlob** and Sue Nonemaker provided an overview of assessment instruments under development by the Health Care Financing Administration. The projects are related to the work of the Panel because they incorporate outcome-oriented measures based upon the functional status of patients and they are geared to ensuring the quality of care provided to Medicare beneficiaries.
- 0 Mr. **Friedlob** reported on the Nursing Facility Resident Assessment Instrument mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). An instrument is being developed for the assessment of patients in long term care facilities that encompasses a minimum data set **to** be specified by the Secretary of Health and Human Services. All nursing home residents in Medicare/Medicaid participating long term care facilities would be assessed on admission and during specified intervals thereafter. Assessment findings would serve as the basis for the resident's plan of care and also facilitate an outcome-oriented approach to surveying the quality of care in nursing homes.
- 0 Ms. Nonemaker summarized another initiative from OBRA 87 that concerns the Medicare survey and certification process for home health agencies. An instrument is being developed for use by Medicare surveyors to assess the quality of care provided to home health patients. The proposed instrument will aid the surveyor in determining whether the quality and scope of items and services furnished by the agency attained and maintained the highest possible functional capacity of the patient.



- 0 The Panel also discussed the following issues related to the implementation of a uniform needs assessment instrument: resource commitments required to use the instrument; the population to which the instrument would be administered; the possible development of multiple instruments for use with specialty populations or alternate care settings; the relationship of the proposed instrument to internal and external **assessment instruments** currently in use; and concerns regarding the qualifications and accountability of professionals involved in the assessment process.

## EXECUTIVE SUMMARY

### FOURTH MEETING OF THE ADVISORY PANEL ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

December 7-8, 1988

The fourth meeting of the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) was held December 7-8, 1988, at the Marina International Hotel, Marina **del** Rey, California. The focus of the meeting was to continue deliberations on the content of the assessment instrument and recommendations for its use. The Panel also heard presentations by invited guests on quality assurance and liability issues associated with the uniform needs assessment initiative.

- o The Panel reviewed its progress to date and the plan to accomplish the remainder of its charge to develop a uniform needs assessment instrument for the Secretary of Health and Human Services. HCFA Project Officer Sue Nonemaker reviewed the process used to develop a draft assessment instrument.
- o Chairman Jay Rudman **presented** the draft assessment instrument. The draft instrument was developed to reflect the process and encompass the categories commonly assessed in the clinical setting to determine post-hospital care needs. The draft instrument included the following categories for data collection: sociodemographics; health status (physical and mental); functional status; environmental barriers to **post**-hospital care; family and community resources; nursing and other care requirements; and patient/family values and preferences.
- o The Panel critiqued each category of the draft instrument. Deliberations focused on the need to include individual items and the optimal language by which to measure each item. Revisions were approved within each of the categories.
- o The categories of functional status and nursing and other requirements were referred to subcommittees for further refinement. It was decided that the revised draft of the instrument would be circulated to the Panel prior to the next meeting.
- o Members of the public were given the opportunity to comment on the Panel's work to date and the draft instrument under review. Harry Bryan, Director of the American Hospital Association's Society for Hospital Social Work Directors; Maureen Norton, HOMEDCO; and Burton Silverstein, Marianjoy Rehabilitation Center, addressed the Panel.
- o Incorporating discussion from previous meetings, the Panel deliberated key decision points regarding the use of the uniform-needs assessment instrument. The Panel arrived at

consensus on several recommendations regarding the following areas: qualifications and preparation **of** the assessor; the need for training and other methods by which to ensure uniform use of the instrument; the timing of the assessment; the population to which the instrument should be administered; the use of the instrument in non-acute care settings; and the coordination of data elements to minimize duplication of information contained on internal and external assessment **tools**.

- o Kenneth Kahn, M.D., Chairman of the American Medical Peer Review Association's Continuing Care Committee, addressed the Panel on the impact of a uniform needs assessment instrument on the Peer Review Organizations' (PRO) ability to monitor the appropriateness of discharge planning and the assessment of continuing care needs. He shared his thoughts regarding the draft instrument and suggested items **that** would facilitate the work of the **PROs** should they be required to review assessment findings for quality assurance purposes.
- o Suzanne Mitchell, J.D., provided a brief overview of liability issues related to discharge planning and addressed liability concerns associated with the uniform needs assessment instrument. Specifically, she discussed the effect of a uniform needs assessment instrument on the liability of institutions and clinicians involved in the **assessment** process. She also addressed the legal **implications** of patient attestation on the assessment form and whether recommending a patient attestation process would be prudent.
- o The meeting concluded with a discussion of the proposed content and format of the fifth and sixth meetings.

---

## EXECUTIVE SUMMARY

### FIFTH MEETING OF THE ADVISORY PANEL ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

February 22-23, 1989

The fifth meeting of the Advisory Panel on the Development of Uniform Needs Assessment Instrument(s) was held February 22-23, 1989, at the Hotel Intercontinental, New Orleans, Louisiana. The agenda for the meeting called for continuation of the process necessary to develop the needs assessment instrument. An additional focus for the deliberations was on evaluating the advantages and disadvantages of using the instrument for determining whether payment should be made for post-hospital services provided to Medicare beneficiaries, as required by the Panel's charter.

- 0 In Executive Session, the Panel revisited the issue of patient participation in the needs assessment process. The Panel conducted an exercise designed to facilitate a solution to the previously unresolved issue of patient attestation on the needs assessment form. There was a decision to recommend use of a separate form for the patient's/patient representative's signature, attesting that they had participated in the process.
- 0 Chairman Jay Rudman reviewed correspondence to the Panel. He also outlined a meeting held with Thomas Morford, Director of the Health Care Financing Administration's (HCFA) Health Standards and Quality Bureau. Mr. Rudman reported that Mr. Morford had agreed to conduct a period of review and comment on the draft instrument by experts in the health services delivery field on behalf of the Panel.
- 0 The revised draft instrument, which incorporated changes approved during the previous meeting, was reviewed. Revisions were approved under the categories of "mental health status," "nursing and other care requirements" and "functional status."
- 0 The need for additional changes in the draft instrument was discussed, with responsibility for drafting modifications delegated to several members of the Panel. The Chairman established a schedule by which all Panel members would provide additional changes to categories not addressed during the meeting. Necessary changes would be incorporated and the draft instrument would then be typeset prior to review by the field.
- 0 The Panel reviewed and approved several recommendations regarding the use of the instrument. Areas of discussion included the use of the instrument in non-acute care settings, the development of a method for establishing accountability

for the performance and reliability of the assessment data, and the development of testing and evaluation methodology.

- 0 Members of the public were given the opportunity to comment on the draft instrument and the Panel's work to date. Testimony was given by: Andrew Dibner, Ph.D., Lifeline, Inc.; Carol Gwin, American Occupational Therapy Association; Thomas Granatir, American Hospital Association; Donna Teague, American Nurses' Association; Jamie Boggs, Louisiana State Nurses' Association; Chris Sautter, American Association for Continuity of Care; and Andrea **McTeague**, HOMEDCO.
- 0 The Panel heard a number of presentations from speakers invited to address the potential use-of the instrument for determinations of eligibility for Medicare-covered services. Andrea Ringgold, Chief of the Provider Medical Review Branch of **HCFA's** Bureau of Program Operations, presented an overview of Medicare coverage policy and discussed the role of the fiscal intermediary in eligibility determinations.
- 0 Organizations representing the concerns of skilled nursing facilities and home health agencies were asked to address the usefulness of pre-admission tools by providers to predict eligibility for services. Vera Reublinger, Long Term Care Nurse Specialist, American Health Care Association, critiqued the draft instrument in terms of its usefulness to long term care providers. Joyce Ollis, Director of Home Health at Louisiana's **Rapides** General Hospital, spoke on behalf of the National Association for Home Care.
- 0 Representatives of third party payers were also asked to discuss the implications of a uniform needs assessment instrument for their organizations. Speakers included Marilyn Cassell, Nurse Consultant Supervisor for Aetna Life-Casualty, and Sharon Mays, Account Executive for U.S. Administrators. Ms Mays oversees the administration of benefits for retired miners covered under the United Mine Workers Health and Retirement Funds.
- 0 Ms. Cassell and Ms. Mays reviewed medical necessity criteria for post-hospital services and presented overviews of the process by which decisions, for coverage of services are made for their respective programs. They also critiqued the draft instrument in terms of its utility for decisions regarding coverage for post-hospital extended care services.
- 0 The Panel focused their evaluation of the potential utility of the needs assessment instrument for eligibility determinations according to several areas. They examined the types of information that are needed to make a determination regarding skilled nursing facility or home health services under the Medicare program and then reviewed items that would need to be added to the needs **assessment** instrument for it to be of use to fiscal intermediaries and/or third party payers.

- 0 The Panel also discussed the potential contribution to the process of eligibility determination that could be made by the needs assessment instrument and whether it should be used as a vehicle to determine payment for services provided to Medicare beneficiaries.
- 0 The Panel reaffirmed that an effort had- been made to have assessment items be consistent with Medicare eligibility criteria and felt that it may be possible to use assessment data as supporting documentation for eligibility determinations. However, the sense of the Panel was that the uniform needs assessment should not be the primary source of information for eligibility determinations, believing **thatthe** integrity of the assessment would be compromised should reimbursement issues supersede the clinical focus necessary for an accurate assessment of continuing care needs.
- 0 Positive factors that may result from using the instrument to supplement information provided to fiscal intermediaries include the provision of a more complete picture of patient care needs and an improvement in the consistency of the determination process.

## EXECUTIVE SUMMARY

### SIXTH AND FINAL MEETING OF THE ADVISORY PANEL ON THE DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT(S)

July **24-25**, 1989

The sixth and final meeting of the Advisory Panel on the Development of Uniform **Needs Assessment** Instrument(s) was held July **24-25, 1989**, at the Washington Marriott, Washington, D.C. The agenda for the meeting called for a review of the responses generated during a period of informal field review and comment on the Panel's preliminary recommendations. The Panel's discussion focused on the refinement of the draft needs assessment instrument and recommendations for its use.

- o In Executive Session prior to beginning the public portion of the meeting, Panel members reviewed the plan to complete their recommendations and discussed the process by which they would report to the Secretary of Health and Human Services.
- o In calling the final meeting to order, Chairman Jay Rudman recapped the Panel's desire to conduct a period of informal review and comment by experts in the health care community prior to formulating final recommendations to the Secretary.
- o The draft needs assessment instrument and recommendations for its use had been circulated to 261 potential respondents who included national associations, content experts with wide ranging expertise and a stratified random sample of providers of hospital, skilled nursing and home health care. HCFA had contracted with John Feather, Ph.D., to perform an analysis of the comments.
- o Dr. Feather presented an overview of his analysis, based upon an extensive summary he had prepared for the Panel. He organized the concerns of respondents around five major themes: the purpose of the needs assessment instrument, issues related to patient participation and rights, coordination with other State and Federal forms, qualifications and training needed by the assessor, and the time and cost of implementing the instrument.
- o Dr. Feather also **critiqued** the content of the needs assessment instrument. The field's review had generated many suggestions for adding, deleting or revising items on the instrument. However, there was no clear consensus among respondents other than a general suggestion that many items required additional space for documentation.
- o Members of the public were given the opportunity to comment on the draft instrument and the Panel's work to date. The following provided testimony: Thomas Granatir, American Hospital Association; Maureen Norton, HOMEDCO; Carolyn

Hatzis, Fairfax Hospital; Marilyn Burlenski, American Association for Continuity of Care; Harold Pincus, M.D., American Psychiatric Association; Sandra Butcher, George Washington University Medical Center; Steven White, Ph.D., American Speech-Language-Hearing Association; Harry Bryan, American Hospital Association's Society for Hospital Social Work Directors; and Carol Gwin, American Occupational Therapy Association.

- 0 The Panel discussed numerous recommendations regarding the use of the instrument and adopted motions to clarify the purpose of the instrument, the process for performing the needs assessment, the need to compensate providers for the cost of performing the assessment and the timing of the assessment. These recommendations regarding the use of the instrument will be added to those previously approved by the Panel for submission to the Secretary.
- 0 Using suggestions generated during the period of field review, the Panel considered motions to revise the draft needs assessment instrument. The Panel adopted revisions in each section of the instrument, with several changes made to clarify the intent of items being assessed and facilitate the use of the form.
- 0 Substantive revisions were adopted in the functional status and summary sections of the instrument. The functional status rating scale was simplified to incorporate a four point scale: "independent," "minimal assistance" (includes supervision, verbal cueing or minimal physical assistance), "moderate assistance" and "dependent." Items to assess a patient's ability to communicate from a **functional** perspective were also added to this section.
- 0 The Panel deliberated the intent of the summary section, questioning whether it was to summarize the needs assessment or develop a plan for continuing care. The Panel believed that the development of a discharge plan went beyond the mandate to assess needs for continuing care. Revisions were made to allow for a summary that would identify options for care based on the needs of the patient.
- 0 Because of the full agenda for the meeting, the Panel did not consider preliminary chapters of their report to the Secretary. A plan to complete the revisions to the draft instrument and the Panel's report was discussed.
- 0 Acting Health Care Financing Administration (HCFA) Administrator Louis B. Hays praised the efforts of the Panel members and congratulated them on the successful completion of their charge.
- 0 Wayne Smith, Ph.D., Director of Survey and Certification for **HCFA's** Health Standards and Quality Bureau, thanked the Panel



members for their tremendous contribution to the uniform needs assessment initiative. He presented them with Bureau Director's Citations as an acknowledgement of **HCFA's** appreciation of their efforts.

- 0 Chairman Rudman adjourned the final meeting of the Advisory Panel after saluting the efforts of members and HCFA Project Officer Sue Nonemaker. He expressed his heartfelt thanks for their cooperation and enthusiasm.



## **APPENDIX D**

### **Analysis of HCFA-Solicited Comments on a Draft of the Uniform Needs Assessment Instrument**



# **Analysis of HCFA-Solicited Comments on the Draft of the UNIFORM NEEDS ASSESSMENT INSTRUMENT**

**Contractor Identification:** This analysis and summary of HCFA-solicited comments to the draft of the Uniform Needs Assessment Instrument was carried out by John Feather, Ph.D., Director of the Western New York Geriatric Education Center, State University of New York at Buffalo. Sue Nonemaker, R.N., M.S., was the Project Officer for HCFA, and provided a great deal of assistance and important suggestions. Additional assistance was provided by Patricia O'Hare, R.N., M.S., Dr.P.H., of the Georgetown University School of Nursing, and Patricia C. Hanson, R.N., President of Healthcare Management Services of Minneapolis, Minnesota.

**Methodological Overview:** The Health Care Financing Administration (HCFA) solicited comments on the draft of the Uniform Needs Assessment Instrument through a letter dated April 13, 1989, from Wayne Smith, Ph.D., Director, Office of Survey and Certification, Health Standards and Quality Bureau. The letter was sent with a packet of materials that included a copy of the draft instrument, definitions and instructions for assessment of functional status, recommendations from the Panel on the use of the instrument, a background statement on the instrument, and instructions for preparing comments.

The instructions for preparing comments requested that responses be structured according to three areas: provider prospectives; beneficiary perspectives; and fiscal intermediary perspectives. All respondents were asked to review the draft instrument for content validity. Additionally, providers were asked to critique the instrument in terms of its application in the clinical setting and the administrative process that would be required to coordinate and manage completion of the form. Respondents representing the concerns of beneficiaries were asked to analyze the instrument in terms of its capacity to allow the patient to participate in the assessment process to the extent that he or she desires. Fiscal intermediaries were asked to address whether information needed for coverage determinations (i.e., medical necessity criteria) would be captured on the instrument and what type of administrative process would be necessary to utilize data for coverage determination. Respondents were asked to be specific and constructive in their comments.

Responses were solicited from 261 individuals and organizations, including 49 associations, 62 specialists and other content experts, and stratified random samples of 100 hospitals, 25 skilled nursing facilities, and 25 home health agencies. The following variables were used to stratify the random samples: geographic location; size; urban, rural, or teaching status; specialty status (psychiatric, rehabilitation, children's, military, Veterans Administration); and ownership status. The hospital sample was derived from the American Hospital Association membership data, which includes hospitals accredited by the Joint Commission on the Accreditation of

Healthcare Organizations and hospitals certified under the Medicare Conditions of Participation. The samples of skilled nursing facilities and home health agencies were obtained from HCFA files of certified providers.

Responses were received from 25 associations, 27 individual specialists, 28 hospitals, no skilled nursing facilities, and 3 home health agencies. In addition, 21 comments not directly solicited by HCFA were received. The lack of response from skilled nursing facilities and home health care agencies is a cause for concern, although some associations and individual content experts representing these groups are represented. If the instrument is to be used by non-hospital facilities, further comment may be needed during another period of comment on the Panel's final instrument or during a field testing phase.

Throughout this report, the draft Uniform Needs Assessment Instrument is referred to as "the instrument" to distinguish it from other federal forms discussed by respondents.

**Overview of Comments:** Most respondents complimented the Panel on its hard work and the comprehensiveness of the draft instrument, feeling that the Panel has done a good job in meeting the mandate of the Congressional legislation.

A summary such as this fails to give a true sense of the richness and diversity of the comments and suggestions. The respondents devoted a great deal of effort under a tight deadline in order to give the Panel a sense of how the instrument would help or hinder their work in providing service to or advocating for Medicare beneficiaries.

This report, which lists comments and criticisms sequentially, inevitably gives the false impression of overwhelming opposition to the instrument, since each item is extensively critiqued. It is important to remember that in most cases, respondents discussed only the few items that were of particular interest to them. The other sections were either not discussed or considered to be adequate as they stood.

Since few respondents commented on all of the questions or followed the outline given in the instructions, it is not possible to provide an numerical analysis of the responses. Throughout the report, the numbers of respondents commenting on a particular point are given.

This report is divided into two sections, the first containing general themes running throughout the comments, followed by item analysis of each section of the instrument.

## GENERAL THEMES

The general themes raised by the respondents have been the focus of discussion in previous Panel meetings. They are listed here in order of the frequency of mention.

## *Purpose of the Instrument*

The most common concern of the respondents was the purpose of the instrument. Positively, most thought it could be used effectively as a tool to evaluate posthospital discharge needs for continuing care, which is the stated goal of its development. Negatively, respondents expressed both anxiety and confusion over the other uses to which the instrument would be put, reflecting perhaps the ambiguity of the original legislative mandate. The concern was both stated explicitly and implicit in the confusion found in some respondents' assumptions as to the goals.

The large majority of respondents felt the instrument would meet the explicit goal of the assessment. As stated in "Background Regarding the Uniform Needs Assessment Initiative" sent to respondents;

OBRA specified that the needs assessment instrument must include measures to evaluate the needs of the individual in terms of functional capacities, and the nursing and other care requirements necessary to meet health care needs or assist the patient in living with functional incapacities. The instrument must also evaluate the social and familial supports available to the individual to meet their needs.

The instrument was to be developed for potential use by discharge planners, hospitals, nursing facilities, home health agencies and other health care providers and fiscal intermediaries. Providers should be able to use the instrument to evaluate the post-discharge needs for continuing care.

Respondents agreed that the instrument was comprehensive, and contained most or all of the information necessary to determine continuing care needs. Many suggested specific items to be changed or added, and this information is found below in the item analysis section of this report.

However, respondents did not necessarily agree that the instrument would be *useful* or improve the quality of the discharge planning process. Concerns focused on:

- \*duplication of information required by other forms currently required for payment determination;
- \*amount of additional time and cost that would be required to complete the instrument;
- \*patient involvement ; and,
- \*potential use as a tool for decisions regarding whether payment would be made for services provided to Medicare beneficiaries.

Each of these concerns will be addressed separately below.

Many of those critical of the instrument focused on its potential as a way of determining payment for Medicare services. As stated in the "Background" document:

The Secretary's report to the Congress on the needs assessment instrument must also include an evaluation of the advantages and disadvantages of using the instrument to determine whether payment should be made for posthospital extended care services and home health services provided to Medicare beneficiaries.

Some felt that the instrument had sufficient information to be used for this purpose, and others felt it did not. Most of the discussion, however, focused on whether the instrument *should* be used in this manner. Those who felt that it should, discussed the advantage of using a single form to consolidate information and replace the many forms presently required for payment determination. Some of these respondents assumed that such a consolidation was the purpose of the new instrument.

Those who opposed its use for payment determination did so on a variety of grounds. Some felt the instrument did not contain all the information that would be necessary to replace the other forms, and pointed to a lack of specific information about the physician's plan of care in particular. Some had the suspicion that the instrument could be used to make qualification for Medicare long term care services even more difficult by collecting more information that could be used as an "excuse" to exclude beneficiaries. Some were concerned that, whatever the stated intention of HCFA, the instrument would in fact be used by the Peer Review Organizations to determine eligibility for benefits, with the result being that an even greater number of patients would be denied access to services.

Whether or not the instrument is used for payment decisions, a number of respondents commented on the lack of a clear relationship between the patient needs identified by the assessment and the decision on posthospital care. As one respondent stated the concern: "The basic premise underlying the document's structure is that the discharge planning process is strictly inductive; an assessment of needs leads to a statement of service options which is matched to community resources." The assumption is that once the "facts" have been gathered, the decision will be clear. Some suggested the use of a scoring system to arrive at a final determination of the appropriate posthospital setting for care.

In a similar vein, some respondents wondered why the instrument has no "algorithm" or scoring mechanism to arrive at a final "score" that would lead to a decision on posthospital care. These respondents were generally those who thought the purpose of the instrument was payment determination for posthospital services. Without such a scoring system, it was unclear to these respondents how the form would be used.

In summary, the lack of clarity in the Panel's legislative mandate on the purpose of the Uniform Needs Assessment Instrument was reflected in the respondents' confusion regarding the purpose of the needs assessment initiative. Beneath some of the criticisms was the fear that, while the instrument is being discussed as an assessment of continuing care needs, its "real" purpose is to provide HCFA with more information to deny payments. In addition, there is the fear that this massive new document will "drop from the sky" on top of health care providers unexpectedly, without sufficient warning or input. Recent experience with other



regulation has heightened this concern. These comments reflect the problem, already evident to the Panel through its public hearings, that no “research tool” is developed in the abstract, and that its implications and suspected motives will be carefully scrutinized.

### *Patient Participation and Rights*

The degree to which beneficiaries and their families should participate in the Uniform Needs Assessment process was the second most common area of interest. Many responded to the general issue of patient involvement in assessment, and others commented specifically on the “Patient Attestation of Participation” form that the Panel proposed be signed by the patient or representative to attest to his or her involvement in the process.

Many respondents expressed concern with the confidentiality of patient information being collected by the instrument. If the purpose of the instrument is to ensure continuity of care, then it would make sense to send the information to the long term care providers to whom the patient is being referred. However, confidentiality is more difficult to assure if multiple organizations are involved, and there was concern that long term care agencies could use the information (especially demographics such as race or education) to refuse access to a qualified beneficiary.

Several respondents thought some of the questions were (or would be perceived by patients as) an invasion of privacy. One continuity of care professional organization “field tested” the instrument and had this response from patients. As will be discussed below in the item analysis, the questions in Sections VI (Family and Community Support) and VII (Patient/Family Goals and Preferences) were particularly sensitive, since they may reveal the unwillingness of family members to care for the patient. In addition, it was unclear how this information would be used once it is collected. Many also felt that the amount of space given to these sections was completely inadequate.

Advocacy groups in particular were concerned that this instrument would be used to develop and present to patients their “one and only” choice for continuing care services. The use of this official, complex, and somewhat intimidating instrument might lead patients to believe that the discharge planner’s recommendation was the “best and final offer,” and that to object would mean receiving no services at all. These advocates remind the Panel that the final decision on continuing care is *always* the patients.

Some commented on the “Patient Attestation of Participation” form itself. While the majority of respondents either liked the idea of a patient attestation form, or seemed to assume that it was required by Medicare regulations, comments ranged widely. At one extreme, a few respondents felt that the attestation form implied professional misconduct on the part of hospital staff, and at the other, one respondent wanted each question on the entire instrument discussed with the patient before the attestation was signed.

Many were unsure of the usefulness of the attestation form in its present wording. Patients are simply saying that they “have been consulted/have participated in the needs assessment.” What do these terms mean? One beneficiary group felt that the patient should sign a summary of the discharge plan based on the assessment, or at least in Section VIII (Summary of Assessment of Needs for Continuing Care), rather than just attest that he or she was consulted. The consequences of signing and not signing the form are also not clear. If the patient was consulted but disagrees with the recommendation for continuing care services, should they sign?

A few opposed the attestation process entirely, even in its current limited form, feeling (in the words of one respondent) that it is “cumbersome, inappropriate, and implying unethical behavior.” This point of view was expressed by very few, however.

In summary, many respondents commented on the general issue of the patient rights implications of the assessment, as well as on the specific patient attestation included in the draft. The majority felt that patient participation was essential, but questioned whether the current instrument adequately addresses this need.

### *Coordination with Other Forms*

Coordinating the Uniform Needs Assessment Instrument with other required forms was a major concern of respondents. Indeed, a number assumed that the *purpose* of the instrument was to merge all Medicare forms for long term care payment determination into this one instrument. There was opposition to the use of the instrument if its sole purpose was to collect information on continuing care needs with no coordination with other forms.

In addition to replacing other forms, many respondents raised the importance of making the needs assessment instrument consistent with existing federal forms, and gave a number of specific examples, including:

- \*the new HCFA Mental Retardation/Mental Illness Preadmission Screening and Annual Resident Review (PASARR) form
- HCFA Forms 485, 486, 487 for home care
- the new Minimum Data Set for Nursing Facilities
- \*Medicare speech-language pathology guidelines
- \*Medicare discharge planning regulations (OBRA 1986)

A number of comments pointed out that some questions did not use current Medicare-mandated terminology. These are specified in the item analysis below.

Concern for coordinating the new instrument with existing forms is one area in which the confusion over the the purpose of the whole Uniform Needs Assessment initiative was most apparent. If the purpose is to develop a comprehensive instrument that can replace forms currently required for payment determination, then other questions need to be added in certain areas. If the purpose is to collect information on

continuing care needs in a uniform fashion nationally, then many are concerned with the additional paperwork. The administrative and resource requirements of the instrument are considered in more detail below ("Time and Cost of the Instrument").

### *Qualifications and Training of the Assessor*

The "Recommendations Regarding the Use of the Needs Assessment Instrument" prepared by the Panel and sent to all respondents state:

Performance of the uniform needs assessment should be conducted by qualified and trained personnel without restriction to a professional group or discipline. Such personnel should be under the supervision of a registered nurse, social worker or other qualified personnel. Each health care setting would designate those individuals responsible for coordinating input and completing the assessment.

The comments on this issue once again reflected some confusion on the purpose of the instrument. In this case, the confusion pertained to whether the instrument was intended as a compilation of information already found in the patient's chart, or would require a complete new assessment by an interdisciplinary team.

Among those who felt the instrument was a compilation of information already collected during the course of treatment in an acute care setting, respondents differed on whether or not they routinely collected all the information needed to complete the instrument. Those that did not currently collect the information at the required level of detail were concerned about the time that would be needed to complete the instrument.

Among those who assumed that the instrument was to be used as the basis of a *new assessment*, there was concern at the number of individuals and disciplines that would be required to participate in the process. A number of discipline-specific professional organizations responded that members of their discipline were solely qualified to answer specific questions on the instrument relevant to their discipline. The number of individuals involved in the process would be large, and would need to be coordinated. There was, however, no clear consensus on who should be responsible for coordinating the process.

One professional organization of therapists raised an issue that is potentially important for the *name* of the instrument. Their contention was that, in many states, only licensed members of a discipline can perform an action termed an "assessment" in that discipline. By calling the instrument the *Uniform Needs Assessment*, HCFA may imply that all relevant disciplines must be involved in each assessment. This needs further investigation and clarification.

Most respondents, however, felt that nursing and social work, the disciplines currently most linked to discharge planning, were the most appropriate personnel to fill out the instrument. However, a number indicated the need for more systematic

collection of information on the physician's plan of care, so that the continuing care options did not conflict with what the physician may have ordered for the patient.

Many respondents were concerned about the training of assessors and the manual for the instrument. While proposed by the Panel to ensure consistent application of the instrument, they have yet to be developed. Some felt uneasy about rating the usefulness of the instrument, since so much of its practicality depends on these factors.

Several facilities indicated their willingness to act as sites for field testing of the instrument.

### *Time and Cost of the Instrument*

Many respondents were concerned about the amount of time needed to complete the instrument, and the number of staff required. A number made estimates of the time required to complete the instrument, and some actually tried using it with their patients.

The estimates of time needed to complete the instrument varied, once again, according to whether the respondent saw the instrument as a compilation of previously collected data or a new assessment. Those who viewed it as a compilation estimated the time for completion between 15 minutes and 1-1/2 hour, with an average estimate of about 45 minutes per patient. Those who felt it was a new assessment estimated between 1 hour and 5 hours per patient, with an average of about 1-1/2 hour.

Several respondents estimated the cost of using the instrument for their facility. Interestingly, few respondents categorized patients by whether they were "high risk" or not, even though the "Recommendations Regarding the Use of the Needs Assessment Instrument" stated that the instrument is to be used for high risk patients only. Projected cost factors were generally based on all Medicare patients for the facility.

The following examples give a sense of the range of estimates given by respondents:

- a 700 bed university teaching hospital estimated that 11.5% of its 26,000 annual discharges, or 3,023 patients, are Medicare patients needing rehabilitation, nursing home, or home care. Assuming an average completion time of two hours per patient, this would require 6,046 hours of labor and add 2.9 full-time equivalents to the discharge planning workload, at a cost of \$125,860 annually or \$41.63 per discharge. This would not include the cost of evaluating patients who die or decide to go home without services.
- a continuity of care professional organization had several of its members field test the instrument, and they found that the completion of the form took thirty to forty-five minutes *after* all the data had been collected
- a 300 bed community hospital estimated that the instrument would require thirty minutes to transcribe once all the information was available. Based on a

census of 55% Medicare patients, or 5,400 patients annually, it would take 2,700 hours annually to complete the form. At a rate of \$15.50 per hour, it would cost \$41,850 a year, or 1 -1/2 FTE, with associated benefits, office space and supplies.

- a 400 bed community hospital estimated that 85% of its Medicare patients fall into its high risk profile. Projecting the average completion time to be one hour, this would require a total of 350 hours per month, or 2.0 FTEs.

- a 400 bed university medical center estimated that one full time master's level nurse would be needed, in addition to other professionals who would consult or participate on specific sections of the instrument. This was based on an average time of 1 to 2-1/2 hours per completed instrument.

- a 600 bed university medical center based its estimate on all Medicare admissions (19% of total, or 3,800 per year), and an average total time of five hours per completed instrument. This would require 19,000 hours of labor per year, or 9 FTEs, at a cost of \$258,147 per year.

Respondents universally assumed that this cost would have to be borne by the facility, and would not be reimbursed by Medicare. However, they felt that if HCFA required the instrument's use, it should pay for the additional staff needed for its completion.

### *Comparison of Providers, Beneficiaries, and Fiscal Intermediaries*

The concerns expressed by the respondents did not divide neatly according to whether they were a provider, professional organization, beneficiary group, or fiscal intermediary. In general, the professional and provider associations provided more extensive comments on all sections of the instrument. Most individual providers commented on specific questions, and did not follow a particular pattern. As might be expected, many providers were concerned with the time and personnel that would be needed to complete the instrument, but that did not necessarily mean that they were opposed to its use. Few beneficiary groups or fiscal intermediaries responded, making generalizations about these groups difficult. Discipline-specific associations generally discussed the role of their members in performing the assessment, stressing the importance of their members' unique skills.

There did not seem to be any correlation between the types of responses that were generated and the variables used to stratify the sample of hospitals, nursing homes, and home health agencies (e.g., size, urban-rural, ownership). That is, the concerns of large hospitals were not systematically different from those of small hospitals. Once again, comments were generally on specific items of particular interest.

In the item analysis below, the type of respondent making each comment is generally identified. This will give the Panel a better sense of the particular concerns of each type of respondent.

### *Suggestions for Restructuring the Entire Instrument*

Two organizations suggested ways in which to restructure the entire instrument, as well as extensive comments on each of the items.

A hospital provider organization suggested the following general structure (with cross-references to the current instrument in parentheses):

- I. Sociodemographics (Section I)
- II. Health Status (Section II.A.)
- III. Assessment of Needs for Continuing Care (Sections V.4., V.5, V.6., and VI.C.)
- IV. Patient Preferences and Family Support (Sections IV.A., VII.A,B, and C)
- V. Plan for Continuing Care (Sections IV.A.2. and IV.A.3, VI.C., and VIII.B, C, F, and H)

Appendix A: Nursing and Other Care Needs (Section V)

Appendix B: Physical Functioning (Section III)

Appendix C: Mental Functioning (Section II.B.)

Section III would include a screening tool or other mechanism that would identify patients who needed a more detailed assessment of nursing need, or physical or mental functioning, using the assessment materials in Appendices A-C. For Appendices B and C, more comprehensive evaluations should be substituted if more extensive evaluations are required. The organization felt that this structure would enable the assessor to tailor the assessment to the patient's condition and to avoid collecting unnecessary information.

A continuity of care professional association suggested rearranging the sections of the instrument to be answered at different times during the acute care stay. This arrangement would better reflect the flow of the discharge planning process. By arranging the sections in this manner, it would be possible to have more than one person complete the form.

*[to be completed as soon after admission as possible]*

Section I: Sociodemographics

Section IIA: Health Status (move "surgical procedures" and "discharge diagnosis to Section VIII)

Section IV: Environmental Barriers

Section VI: Family and Community Support

Section VII: Patient and Family Goals and Preferences

*[to be completed within 2-3 days of discharge]*

Section IIB: Mental Health

Section III: Functional Status

Section V: Nursing and Other Care Requirements

*[to be completed at the time of discharge]*

Section VIII: Summary of Assessment of Needs (include surgical procedures and discharge diagnosis)

## ITEM ANALYSIS

The following is a summation of comments for each specific section and item on the instrument. The Panel should be aware that most respondents commented on only those few **areas** that were of specific interest to them; few commented on all sections of the instrument. It is difficult to interpret “silence,” as the lack of a response on a particular question could mean that the respondent thought the section was adequate as written or that the respondent had no interest in the particular area. It was generally impossible to distinguish between the two. It is important to remember that the same specific suggestions were rarely made by more than a few respondents, and in no case was the same suggestion made by more than ten respondents.

As mentioned in the general themes section, the Panel should remember that the organization of this section, in which specific comments, suggestions, and criticisms are listed cumulatively, may give the overall impression of widespread opposition to the instrument. This does not accurately reflect the sense of the original responses, which were generally positive.

To give the Panel some sense of the source of the comments given below, a descriptive phrase is used with most comments, either in the summary statement or in brackets following the suggestion. “Professional association” refers to groups such as the American Medical Association or the National Association of Social Workers. “Provider associations” include groups such as the American Hospital Association or the National Association for Home Care. “Beneficiary organizations” include groups such as the the **Grey** Panthers or the American Association of Retired Persons. Where more than one group gave a particular response, it is noted (e.g., “three hospitals”); otherwise, each notation indicates a single respondent for that comment.

The one area of consensus that applies to every section of the instrument is the lack of space to answer the questions. This comment pertained to almost every **open-ended** question in the instrument. If the final instrument is to be approximately the same length as the draft, it will be difficult to incorporate this space without deleting some material.

## SECTION I: SOCIODEMOGRAPHICS

### *General Comments:*

Some respondents questioned the purpose of the items in this section, indicating that the relationship of these questions to the assessment of posthospital care needs should be clarified. One hospital felt that asking for non-essential information was an invasion of privacy, and so it must be clear why this information is needed. A provider association suggested that demographic questions (religion, race, education, employment) should be moved to Section VI (Family and Community Support) if the purpose was to assess possible assets or barriers to care.



### *Specific Comments on Questions:*

**Instructions:** Some respondents [hospitals] were not sure that attaching an admission face sheet would be useful, since they were unclear if it would match the purpose and terminology used in the instrument.

1. **Name:** add “last, first, middle initial” [professional association]

2. **Address:** allow additional space [fiscal intermediary]

4. **Birthdate:** add “age” as well, eliminating the need to calculate from birthdate [hospital]

6. **Marital Status:** Does “single” mean “never married”? [hospital]. Need to add same sex couples and other relationships outside of marriage [beneficiary group]

7. **Religious Preference:** A number of respondents disliked the format of this question. Three hospitals thought the information could be useful as it relates to continuing care needs, such as placement in a religiously affiliated nursing home, possible assistance with care by church-related volunteer groups, restrictions on diet, or treatment options. Others thought the current categories are too broad to be useful [two professional associations, provider association, hospital]. They suggested the manual specify that information be obtained regarding whether or not the person’s religious preference will affect his or her long term care options. A category also needs to be added for “None,” or space created to write in the response [two beneficiary groups]. An additional suggestion was to rephrase the question more in terms of the patient’s values and preferences regarding long term care. It was felt that this question would result in more meaningful information as well as eliminate the need to ask about religion directly.

8. **Race:** A few respondents were not sure of the value of this question, being unclear of its bearing on long term care needs [2 hospitals, professional association]. One was concerned that it could be used by facilities to screen out minority beneficiaries.

9. **Education:** The same concerns were raised as in #8 above. The relationship between education and the need for long term care is not clear, raising concerns as to the purpose of this question [professional association, 3 hospitals, nursing content expert].

10. **Employment Status:** Suggestions included: add “injured worker” [provider association]; add “former occupation” [beneficiary group; home health provider]; add “disabled” [hospital]. A person may be retired and also employed [home health provider].

11. **Health Care Coverage:** Suggestions included:

\*changing “Health Care” to “insurance”

\*adding CHAMPUS to the choices [accrediting body]

- \*changing “guarantor” to “private pay” [hospital provider association]
- \*specify Medicare Part A and Part B [hospital provider association]
- \*creating a section to alert the discharge planner to the need to initiate the forms necessary to qualify the patient for Medicaid
- \*uncertain that “veteran with service related disability” is well understood [professional association; hospital provider association; accrediting body]
- \*adding an option for “no coverage” [hospital]
- \*the term “guarantor” is not clear and rarely used [home health provider; fiscal intermediary].

**12 and 13. Language:** There was a suggestion to combine these two questions into a new “language” section [hospital provider association], or to expand it into a “communication barriers” section by including hearing and speech impairments [home health provider association]. Other comments included: the patient may not *speak* English, but may understand it [hospital]; a person may speak English quite well yet have another “primary language” [beneficiary group]; this section could be covered under the Health Status Section [hospital]; add a “partial” response for those who have limited facility in English [professional association].

**Suggestions regarding other items to be added in this section included:**

- \*date assessment was initiated [hospital]
- \*social security number [hospital; fiscal intermediary]
- \*source of information, including patient, medical record, direct observation, caregiver, health care professional [academic content expert; provider association, professional association]
- \*financial status or income [hospital]
- \*occupation [hospital]
- \*health related behaviors not noted elsewhere, such as smoking and alcohol habits, drug use, and special dietary practices [professional association]
- legal representation, if any [hospital group]

## **SECTION II. HEALTH STATUS**

### *General Comments:*

Respondents differed in their interpretation of the purpose and scope of this section. Some respondents felt that the section was intended to capture diagnostic and prognostic information that could only be provided by the patient’s physician. These respondents believed that more space should be allocated to allow the physician to address both prognosis and the plan of care.

The current version could be used by a variety of professionals, since the terms are general and not specifically physician oriented. However, some of the questions may require a physician’s judgment as to whether or not the health problem will affect post-discharge care needs. In that case, using general or “layman’s” terms is less useful, since a physician will be involved in any case. Some of these issues can be

addressed in the proposed training manual, or through extensive training of the assessors.

A medical association commented that medical condition is the key to the patient's health status and rehabilitation potential. A summary of the patient's medical condition should be part of this section, because the current questions do not adequately address this issue.

A provider association suggested deleting the distinction between Parts A and B, and moving part B (Mental Health) to an appendix with more extensive questions that would be filled out on those patients for whom detailed mental health information was needed. A hospital respondent suggested the need for additional space to reassess these conditions, or, alternatively, specifying at what point these questions will be answered, since the patient's condition changes rapidly during hospitalization.

Any restructuring of this section should be closely tied to the Panel's decision as to which professionals should complete the instrument.

*Specific Comments:* Both parts of this section (A. Physical Health and B. Mental Health) generated a large number of specific comments.

I-4. Diagnoses. Many commented on the need for additional space in all of these questions. A state medical association suggested including space for at least four ICD-9 codes. A professional association felt a clearer definition of "admitting diagnosis" was needed. The items on the instrument seem to assume that the patient is in an institutional setting, when the instrument should be able to be used for community assessment [hospital]. Prognosis, both short and long range, is essential, especially for those entering hospice [accrediting organization, professional association], and should be differentiated from discharge diagnosis.

A provider association suggested revising the section to include principal diagnosis (as defined by Medicare), invasive procedures, and secondary diagnoses. Chronic underlying diseases should be specified in questions A.5. A fiscal intermediary was unclear if A.2. (Subsequent Diagnoses) referred to all diagnoses or only those affecting the current episode of care.

Two hospitals and a fiscal intermediary were concerned that discharge diagnosis (question 4) would not be ready until the medical record was coded, and would delay the completion of the instrument.

Other suggestions for additional information included:

- \*preadmission medications and initial pharmaceutical treatment [professional association]
- \*discharge medications
- \*changing "subsequent diagnoses" to "subsequent functional problems or diagnoses"

## 5. Known Health Problems/Risk Factors

A provider association suggested separating “physical health problems” from “other known problems/risk factors.” The first category would include such factors as chronic cardiovascular, pulmonary, renal, and liver disease, cancer, diabetes, cerebral degeneration, hypertensive disease, and arthritis. The second category would include mental illness, mental retardation, nondegenerative neurological disorders, deafness or hearing impairment, blindness, physical handicap or impairment, substance abuse, falls within the past year, dizziness, obesity, and a history of noncompliance with therapeutic regimen.

Several respondents [provider associations] suggested adding a scale rating the degree to which the problem would affect post-discharge care needs, such as “little consequence,” “moderate consequence,” and “severe consequence.”

Two hospitals and a beneficiary association wanted the *degree* of blindness and deafness defined, since the terms usually refer to total blindness or deafness.

Many respondents suggested additions to the list, including:

- \*multiple diagnoses [professional association]
- \*multiple medications [professional association, provider association]
- \*bleeding disorders and anticoagulant therapy [two hospitals]
- \*chronic pain [home health agency]
- \*peripheral perfusion [home health agency]
- \*multi-infarct dementia and “other dementia” which is not Alzheimer’s or neurodegenerative [beneficiary association, professional association]
- \*separation of dementia types, and distinction from Parkinson’s disease [beneficiary association, hospital, professional association]
- \*if patient with dementia, include influenza, urinary tract infection, constipation [beneficiary association]
- \*hypertension [case management agency]
- \*medication allergies [medical content expert]
- \*insulin therapy [provider association]
- \*previously diagnosed psychiatric disorder [professional association, hospital]
- \*speech or communication impairments [case management agency, professional association]
- \*dental problems [professional association]
- \*swallowing problems [professional association]
- cachexia (wasting away) [professional association]
- malnourishment [professional association]
- dyspnea with minimum exertion [professional association]
- \*generalized weakness [professional association]
- \*frequent hospitalization [hospital]
- \*possible physical, emotional, or sexual abuse [hospital]
- \*vascular disease [provider association]
- \*use of multiple physicians
- \*HIV/AIDS [academic content expert, government agency, hospital]

- \*infectious disease [academic content expert, government agency, provider association]
- \*incontinence [academic content expert]
- \*tuberculosis [provider association]
- sleep disorders [provider association]
- \*psychological stress [provider association]
- \*paralysis [hospital]
- \*allergies [home health agency]
- \*epilepsy [provider association]
- \*spinal cord injury or head injury [provider association]
- use of prostheses [hospital, professional association]
- \*basic laboratory tests (e.g., tuberculin skin testing, albumin, screening for diabetes) [professional association]

Some suggested items to be deleted from the list (with the reason for the deletion in parentheses):

- \*fractured bones (included in Section V) [provider association]
- \*pressure ulcers (included in Section V) [provider association]
- \*food/fluid intake problems (included in Section V) [provider association]
- \*tobacco misuse (irrelevant) [two provider associations]
- CVA (found in diagnostic information in questions 1-4) [provider association]
- \*dizziness (patients overreport symptom) [hospital]

Some suggested changing the terminology used for specific items, including:

- \*“Factors that Affect Post-Discharge Care Needs” to “Factors that May Potentially Affect Post-Discharge Care Needs” [hospital]
- \*“pressure ulcer” to “skin integrity” [home health agency]
- \*“non-compliance” to “non-adherence” [nursing content expert]
- \*“substance misuse” to “substance abuse” [hospital]
- \*separate drug abuse into prescription and non-prescription [hospital]
- \*“dizziness” to “problems of balance” [beneficiary association]
- \*“blindness” to “visual impairment” [beneficiary association, professional association]
- \*“deafness” to “hearing impairment” [professional association]

**6. Additional Information:** Many respondents commented that more space is needed. The manual should have examples of the types of information that might be included here [two professional associations, fiscal intermediary, accrediting organization].

One professional association suggested greatly expanding this section to include a more extensive medical and nursing narrative, which would include comments on:

- the patient’s level of impairment with and without assistive devices
- \*stability of the patient’s medical condition at discharge
- \*patient’s rehabilitative potential

- \*permitted activities
- \*the need for safety measures
- \*durable medical equipment (DME) needs
- \*frequency with which the patient needs to see the physician

The same group felt that the signature of the physician should be required as part of the assessment of the patient's physical health, and should appear somewhere on the instrument.

Another professional association suggested adding factors that may be indirectly related to various health conditions, but have a significant impact on post-discharge care needs, such as fatigability, level of distress, and ability to focus and set priorities.

## **Section B. Mental Health**

A provider association felt a new section should be added for Level 1 screening for mental illness and mental retardation as required by the Preadmission Screening and Annual Resident Review (PASARR) provisions of OBRA 1987. Another provider association thought that a number of the conditions in this section would trigger a level 2 screen, requiring close coordination of the forms.

Another provider association felt that "mental illness" and "cognitive function" should be included in this section. One professional association suggested changing the title from "mental health" to "mental status," while another felt that the section should address both cognitive and affective function. As mentioned previously, one provider association felt that this section should be separated from the main instrument, renamed "mental functioning," and filled out for those patients who warranted a more detailed level of assessment.

A hospital suggested adding questions here ascertaining if the patient were developmentally disabled, or had a history of mental illness, previous institutionalization, or drug therapy.

A provider association was concerned about the difficulty of using this section in a scoring system that would lead to a discharge decision, and felt that a number of the items (impaired comprehension, impaired expression, agitation, unusual behavior) were vague and subject to individual assessor interpretation. This assumes, of course, that such a scoring system will be used in the instrument.

One hospital felt that if the assessor was trained, the descriptive comments for each condition could be dropped.

### **1. Level of Consciousness**

Many respondents found the level of detail in this question not useful in determining continuing care needs. A provider association suggested three categories:

- alert

- \*semi or demi-conscious (lethargic, drowsy, obtunded, or stuporous)

- \*comatose (unresponsive)

A professional association thought the choices could be limited to “alert” or “comatose.” A medical professional association suggested that a more useful scale for non-hospital settings would be: alert; responsive; and non-responsive, focusing on the patient’s ability to participate in his or her care. A hospital suggested combining “obtunded” and “stuporous.” Another thought it was important to indicate the *reasons* for a decreased level of consciousness, such as use of certain medications [beneficiary association]. One provider group thought that “normal reaction time” was subjective. A fiscal intermediary felt that space was needed to comment on conditions that cannot be contained in a check-off format.

Three hospitals pointed out that the patient’s level of consciousness can change during the day, and one respondent suggested the use of a scale indicating whether the condition occurred always, occasionally, or never. A medical content expert was concerned that these levels were misleading, since combinations or modifications can occur, such as “alert, but reaction time affected by paralysis” or “alert, but psychotic.” A beneficiary association found the distinction between “drowsy” and “obtunded” unclear.

A number of respondents made suggestions regarding changes in terminology, including:

- \*separating “comatose” from “persistent vegetative state” [medical professional association]

- \*substitute “delirious” for “drowsy” and “lethargic”

## 2. Cognitive/Behavioral Factors

Two professional associations strongly objected to placing communication and expression disorders in the “Mental Health” category, and recommended that these questions be moved to Section III (Functional Status). However, another professional association felt that comprehension and expression *should* be placed here.

Two respondents suggested using a scale to rate the degree of impairment caused by each of these conditions. A hospital was confused by the phrase “adversely affect post discharge care needs,” wondering if it meant “adversely affect *obtaining* post hospital care needs” or “affect *choice* of post hospital care needs.” A professional association suggesting weighting the items as to their importance in affecting post-discharge care.

Several groups [hospitals, provider association] thought the short summary statements clarifying the scope of each item were valid and useful.

A beneficiary group suggested the need to have a category for irritable, angry, hostile, stubborn, or verbally abusive behavior that is short of “assaultive.” This is

common in Alzheimer's patients. These patients also cannot recognize their need for care, which is sometimes confused with denial [professional association].

A number of respondents suggested changes or additions to the specific items in the question, including:

- impaired comprehension*: assess with regard to the ability to use equipment or participate in treatment in the posthospital setting [professional association, accrediting organization]
- \*dividing *impaired orientation* into "partial" or "total" disorientation [case management agency]
- \**depression*: include anger, resistance, and denial [hospital]
- unusual behavior*: add inappropriate behavior (e.g., disrobing) [hospital, professional association]

The following were suggested as additions to the list:

- \*impaired attention [provider association]
- \*impaired visual perception [provider association]
- \*irritable, angry, hostile behavior that is short of being assaultive [beneficiary association]
- \*suicidal [provider association, hospital]

### **SECTION III. FUNCTIONAL STATUS**

#### *General Comments:*

There was concern over the measurement strategy employed in this section, since it contains different types of information and levels of assessment detail. For example, the mixing of a 4-part rating scale (Section A) with a double dichotomous choice (two sets of "yes-no" questions - Section C) was thought by a professional association and a provider group to make the section difficult to use to determine the level of care needed or to make payment determinations.

One of the greatest concerns expressed about this section was that the functional status of patients changes rapidly during hospitalization, and the instrument has no mechanism to capture this information. A professional association indicated that functional status is best assessed after the patient's medical condition has stabilized, but, under Medicare prospective payment, that is the point at which the patient is discharged. Therefore, it is unclear if the information being gathered would be useful in discharge planning. For this reason, a provider association suggested removing this section altogether and making it an appendix that would be filled out only for those patients for which detailed information on functional status was thought to be essential.

Another concern pertained to the source of information for this section. Two hospitals and an academic content expert felt that section C (Instrumental Activities of Daily Living) would probably be provided by report from the family or patient, as these



items are hard to assess in the hospital. The reliability of this information was questioned.

A home care provider suggested that it would be helpful to include in this section a question on the distance the individual could walk before becoming short of breath. This would help in the determination of “homebound” status, as well as providing useful information regarding the patient’s need for services.

Finally, some respondents found the layout of the section, especially the position of section B, confusing.

#### *Specific Comments:*

**Activities of Daily Living (ADLs): Key.** The scheme for rating ADLs generated a large number of comments from diverse respondents [hospital, provider and professional associations, home health agencies, a case management office, and a nursing content expert]. Most of the concerns centered around the wording of some of the levels, and the complexity of the scale. Some did not feel this level of detail was useful or necessary in an instrument designed to capture continuing care needs, and many were concerned that discharge planners would not be able to find all the information in the charts that was needed to choose the correct category.

Some respondents felt the key would be difficult to use, requiring the assessor to refer back to it in order to rate each item. There was a suggestion to incorporate specific levels under each item, facilitating ease of completion.

A case management group liked the key, but felt that it was essential that the training manual emphasize that the definition applies to the level at which the client can safely perform an activity. A state medical society felt the levels were appropriate and the definitions useful in achieving a more multilevel approach to long term care assessment (rarely than simply distinguishing between skilled and intermediate care), consistent with new OBRA guidelines.

The terms “less than half the activity” and “reasonable amount of time” were seen as particularly problematic [provider association, professional associations, hospitals, nursing content expert, case management agency]. These terms may be meaningful as part of developed scales administered by well trained assessors, but if the instrument is to be used by a variety of professionals, these terms are not intuitive or self explanatory. Although an eight page document on “Definitions and Instructions for Assessment of Functional Status” was included in the material sent to all respondents, most apparently did not read the document or were still confused by the terms. It was generally impossible to tell which of these was the case, since few respondents referred to the instructions.

A provider association suggested using the same scale for both parts A (ADLs) and C (IADLs), using only the categories “independent,” “somewhat independent,” and “dependent.”

## Levels of Independence

1. Complete Independence: no specific comments on this item.
2. *Modified Independence*: There were many criticism of the phrase “requiring more than reasonable time” as ambiguous and open to too much interpretation. A professional association responded, “elderly people respond and move more slowly than younger people,” and suggested using the concept “more time than is usual, considering limitations of independent function caused by pain, dyspnea, generalized weakness, etc.”
3. *Modified Dependence*: This category was criticized by a number of respondents as too complex. A professional association suggested the use of a seven point (1-7) scale rather than a four point scale with one category further subdivided into three categories. As mentioned above, there was a great deal of criticism of the phrase, “at least half of the activity,” as difficult to interpret. One respondent suggested the word “partial” instead.

Under 3B and 3C, a professional association suggested changing “contact assistance” to “physical assistance,” since this would be more consistent with conventional usage. Another suggested adding to 3A “verbal cueing to anticipate safety hazards or to follow the sequence of activity.”

4. *Complete Dependence*: Once again, there were a number of suggestions that the phrase “less than half of the activity” be dropped because it was confusing. A professional association felt that by equating “complete dependence” with the inability to perform “half an activity,” the Panel failed to recognize that patients’ performance can be increased with assistive devices, and inappropriately ignores rehabilitative potential. A suggested substitute was “unable to perform activity.”

### A. Rate Level of. Independence For The Following:

A home health agency pointed out that fiscal intermediaries tend to see lack of independence in ADLs as being “custodial,” and therefore not covered under Medicare. A professional association felt that the question does not document the patient’s progress over time and across care settings, which would be consistent with a rehabilitative model of care. This group suggests adding a grid, so that the same questions are asked at the point of hospital admission, hospital discharge, potential in one month (determined at discharge), potential in three months (determined at discharge), at admission to nursing home or home health agency, and at one month from admission to a nursing home or home health agency.

Comments on specific items included:

*\*eating*: A professional association suggested expanding the category to include: chewing food, swallowing, oral discomfort, and lung aspiration. This group felt that the question in Section II. 5 (Known Health Problems) that reads “food/fluid intake problems” is inadequate to capture the information needed. A hospital was concerned that patients who rely on enteral or parenteral feeding

are classified as “completely dependent,” although they are very different from those who need total assistance with eating (i.e., must be fed by hand). This group suggested making self administration of enteral or parenteral feeding a separate category. A provider association was concerned that although swallowing was mentioned, there was no place to indicate a swallowing impairment, as opposed to being unable to use eating utensils. A hospital pointed out that, in the instructions, “opening containers, buttering bread, etc.” appears both as part of “meal preparation;” and as part of the-definition of “supervised eating.”.

*\*bathing:* A home health provider wondered why it was defined as only from the neck down, since there is no other place to mark the ability to wash the face.

*•dressing:* A professional association suggested adding the following underlined sections: “setting out clothing and dressing/undressing entire body, including donning and removing necessary prosthesis/orthosis”.

*•locomotion:* A hospital felt the identifiers were cumbersome and incomplete, and needed a “non-weightbearing” identifier. A professional association felt this category should be further split to incorporate change in the patient’s capacity for movement, and differentiate between walking, use of a wheelchair, climbing stairs, and movement outside the home. Two hospitals suggested adding “use of walker” and “use of guernsey” to the “most frequent mode of locomotion” category, and not to limit wheelchair use to indoors [professional association]. There was another suggestion to change the item to recognize the ability to climb stairs and move outside the home.

Suggestions for new categories to be evaluated from a functional perspective included:

- \*fluid intake/hydration [hospital]
- \*oxygen dependence [professional association]
- \*ventilator dependence, continuously or intermittently for any or all activities [professional association]
- \*speech (i.e., the individual’s communication functioning that is not related to mental functioning but which is a coachable aspect of physical functioning) [provider association]
- \*expressive and receptive communication [rehabilitation provider association]
- \*grooming (hair, mouth, shaving, and nail care) [home health provider association, professional association]
- rate the level of independence in the use of assistive devices [professional association]
- “not applicable (bed fast)” [fiscal intermediary]

## **B. Medical Restrictions**

Respondents [government agency, professional associations, hospital, case management agency] were unclear as to the purpose of this section, and what types of information should be provided. A few felt that questions A and C should already

capture the information and questioned which ratings it would change, while a professional association thought that a physician would be required to fill out this section. It was also unclear whether “above ratings” referred to Section A alone or both Section A and C. As mentioned above, the position of this section on the page did not lead to a clear interpretation of its intent, and additional space was needed.

### C. Instrumental Activities of Daily Living

There was concern that these items need to be assessed in a patient’s home, since they cannot be accurately assessed in the hospital. The other major concern was the dependence on the family or patient’s reporting of these items [hospitals, two professional associations, provider association]. Respondents mentioned that patients are often anxious to go home, and will overestimate their ability on IADLs to facilitate discharge, or they may not have fully realized the effect of a new limitation on their ability to complete IADL tasks.

The complexity of fully capturing IADLs was an underlying concern. For example, an professional association felt that “The IADL list will be useful but does not describe the client’s ability level. For example, ‘assistance available’ for transportation could mean that the need could be met every day or only once a week. For meal preparation, ‘assistance available’ has very significant implications for formal and informal services if the need is for help with meals twice a day, seven days a week, versus once a day from Monday to Friday.” In a similar vein, an accrediting organization felt that criteria will need to be established for the “yes” and “no” categories, if inter-assessor reliability is to be achieved.

A professional organization wanted the question to include a choice of “partial” as well as total assistance, and to capture changes over time. A provider association recommended deleting the reference to the availability of support, since that could be captured in a final section of the instrument assessing the viability of the discharge plan. A hospital thought that the question should be asked of all patients, rather than only those contemplating return to community residence.

Suggestions on specific items included:

- \*meal preparation:* add “safely” to the definition [professional association]
- \*shopping:* One respondent pointed out that all shopping is not equally important (e.g., shopping for food is more important than shopping for clothes). The current wording may measure distances or convenience rather than functional capacity [provider association]
- \*handling finances:* A professional association was concerned as to how this would be defined, fearing that the question leaves too much room for subjective judgment.
- transportation use:* Not clear what is meant here. It should also specify whether or not the patient plans to drive [hospital].

Suggestions of items to be added to the list included:

- laundry [provider]

- \*yard work [hospital]
- \*recreation [professional association]
- \*social interaction [professional association]
- \*mobility outside the home [professional association]
- \*bathing, grooming, dressing [fiscal intermediary]
- \*personal care [hospital]
- \*ability to use appropriate judgment in emergency situations [professional association]

#### IV. ENVIRONMENTAL BARRIERS TO POST-DISCHARGE CARE

##### *General Comments:*

Several respondents suggested changing the title to something less negative, such as:

- \*environmental factors in post discharge care [two professional associations]
- \*environmental considerations/living conditions [professional association]
- \*post discharge physical environment factors [hospital provider group]

or emphasizing the posthospital aspect by changing the title from “post discharge care” to “continuing care” [nursing content expert].

An academic content expert felt this section would be almost impossible to complete without a home visit, and cited some research that shows that, when assessments done in a clinic are compared with those done in the home, an average of two additional problems and four new recommendations are found during the home visit. He suggests that a decision tree should be developed to flag those patients whose disabilities or social situations would make a home visit an essential part of the assessment.

One urban hospital reported that their experience was that environmental barriers play a minimal role in influencing a patient’s decision about continuing care options, since many patients choose to return home with unrealistic expectations about recovery of functional status or to await environmental modifications that can take months.

The identification of “barriers” was also of concern to one advocate for the demented, since, for these patients, an “environmental barrier” would include the inability to react to a fire alarm or operate an elevator correctly. This may not be a concern for all patients.

A hospital was concerned with the hospital’s legal liability if barriers were identified and modifications proposed, but none were carried out. Would the hospital be held liable for sending the patient to a unsafe environment?

Finally, there were suggestions that the section should either be much more detailed, perhaps as a separate section or appendix, or dropped, since the level of

detail here would be difficult to obtain but not be enough for effective discharge planning. A provider association suggested combining this section with Sections VI and VII into a new section entitled "Patient Preferences and Family Support." A hospital suggested that the "yes-no" and checkbox system should be eliminated in favor of a much larger descriptive section. A medical professional association thought the section was not specific enough to be useful for discharge planning.

*Specific Comments:*

## **1. Usual Living Arrangements**

Several respondents [3 hospitals, accrediting agency] felt that the title "usual living arrangements" implied that the patient's arrangements were going to remain the same after discharge, when just the opposite is likely to be true. One suggested "contemplated post-discharge living arrangements" as a more useful title [accrediting agency], while several respondents [hospitals] wanted additional questions on whether these arrangements were still available upon discharge.

Other concerns were that patients may not share this information, particularly if they are living in an unusual situation [government agency, hospital], and that the question format does not make it clear that the assessor should check a box in both columns [case management agency].

Suggested changes on specific items included:

- \*home/apartment:* change "home" to "house," since all of these alternatives may be considered "home" [professional association]. Another suggestion was to add "condominium" to this list [professional association].
- \*skilled nursing or intermediate care facility:* this should be changed to "nursing facility" to be consistent with OBRA 1987 [provider association, accrediting agency]
- \*other:* this may be seen as an invasion of privacy, if the patient lives in an unusual situation [government agency]

The following was suggested as information to be added:

- \*unsafe neighborhood
- \*geographic location of the home [hospital]
- \*remote area/rural isolation [home health agency]
- \*home, but need for services such as day hospital or respite [case management agency, provider association]
- \*homeless/transient [hospital, provider association]
- \*"with children" as a separate category after "with spouse" [professional association]
- \*lack of financial resources [accrediting agency]

## 2. Assessment of Living Arrangements

Several respondents were concerned that this information could only 'be accurately collected through a home visit; otherwise, it would depend entirely on the accuracy of reports from the patient or family [home health provider group, hospital, professional association].

A provider association felt this question should be combined with question 3 (environmental barriers and proposed modifications) into a new section on "home safety and access." This section should capture impediments to discharge to the home and any modifications necessary to accommodate the patient.

Suggested changes on specific items included:

•*noninstitutional, living arrangements*: does "available" mean simply existing in the community or a place for which the patient is qualified? For example, home with home care may be "available," but not feasible because of lack of finances [professional association]. Also the timing of the availability is important (e.g., it may be available, but not until two weeks from date of discharge) [professional association]

\**barriers to building entry*: Change to "entry/~ [professional association]

\**internal barriers*: the manual should give examples, such as whether this includes doorways wide enough for wheelchairs, or stairways [provider association].

\**toilet/tub/shower accessible*: A visiting nurse association pointed out that in many rural and some urban areas, it is still common to find homes without running water or indoor plumbing. Asking if the toilet is "accessible" has a different meaning in these settings. A provider association suggested adding a specific question here if the patient is wheelchair bound as to whether or not the doorway is wide enough for wheelchair access.

The following was suggested as information to be added:

- \*barriers to communication for the hearing impaired [professional association]
- entry stairs and inside stairs [professional association]
- \*doorway size [professional association]
- \*toilet on different level as bedroom [professional association]
- \*kitchen on different level as bedroom [professional association]
- loose rugs [hospital]
- snow or ice-covered walks [hospital]
- \*refrigerator, stove, telephone and/or other utilities in working order [provider association, nursing content expert, hospital, professional association]
- no toilet and/or running water in household
- "at risk" neighborhood or building [hospital]
- \*transportation [provider association]

### 3. Barriers and Modifications

More space is needed here if it is to be a useful question. A professional association suggested changing the wording to “describe needed and proposed environmental modifications,” to be consistent with questions iv.A.2. As mentioned above, there is concern over liability if the need for modifications are identified and proposed but not carried out [beneficiary association, hospital]. Decisions about modifications to the home would also certainly require a home visit. Additional staff and time would be required to perform this type of assessment.

## V. NURSING AND OTHER CARE REQUIREMENTS

### *General Comments:*

The format of the section was of concern to respondents, with the need for additional space voiced most often. Two home health agencies and a home health provider association felt that the documentation that would be needed to justify payment for skilled home care could be contained in these questions, but that there is currently not enough space to provide all needed information. The questions as currently written do not contain all the information required by HCFA forms 485, 486, and 487 used to document eligibility for home health services under Medicare. On the other hand, a hospital felt that a properly done nursing care plan would provide the information needed for items 1, 2, and 3, which would make these items redundant and a duplication of effort. A hospital provider association felt that this section should be an appendix, completed only for appropriately specified patients.

Some respondents requested clarification of when care needs were to be assessed, specifically whether the assessment is for current needs in the hospital, or anticipated needs post-discharge [hospital, fiscal intermediary]. Respondents also mentioned the problem of rapid changes in status of the patient during hospitalization, and the need to be clear as to when the assessment is to be done [hospital, home health agency]. There is currently no place to document changes in status. In a similar vein, a hospital suggested determining care needs closer to discharge.

Respondents generated a large number of suggestions for additional items and/or categories. Using the proposed training manual or other materials, the Panel should clarify why some items were chosen and others were not, if the items listed for each question were not meant to be inclusive.

A hospital provider group and a fiscal intermediary called for a closer linkage between this section and the physician's prescription for care, so that conflicting information would not be sent to home care agencies or nursing homes. A hospital provider group felt that the section would need to be filled out by an RN.

One urban hospital summed up the concerns of many of the respondents in this way: “I understand this section does not constitute medical orders and therefore may not need to be as specific, but often a clear picture of the patient's skilled nursing



needs is crucial in determining whether a patient can return home or requires placement, particularly if the plan of care calls for the patient and/or family to assume responsibility for performing complex procedures (e.g., start TPN infusion, administer IV medication). Frequently the assessment of what is possible in the home involves interviews with patients and family members, extensive predischARGE teaching and skills assessment. Medication management utilizes a tremendous amount of nursing resources in a certified home health agency. This section needs more space [on these issues].”

#### *Specific Comments:*

### **1. Skilled Observation and 2. Monitoring/Supervision/Evaluation**

Most respondents commented on these two items together, citing a lack of clarity in the meaning of the terms [professional association, provider association, hospital]. The term “skilled” was considered to be especially ambiguous [accrediting agency, two professional associations, government agency, two hospitals]. A provider association felt that “skilled observation” was limiting, and would not capture the need for skilled care, of which observation is a component. Another provider association suggested eliminating these questions and incorporating them into a new section on “Assessment of Needs for Continuing Care.”

A medical professional association felt that these two questions should include both the nature of the nursing need as well as the frequency and intensity of needed nursing services, while a hospital thought these questions would require a physician’s order to complete. Another professional association was unclear whether “safety needs” would be included under “Monitoring/Supervision/Evaluation.” A professional association was unclear of what level of supervision was intended (RN, LPN, home health aide, etc.)

If the instrument is to be used in non-acute settings, the heading of the section should read “Check continuing care needs that affect ongoing care requirements” [nursing content expert].

### **3. Therapeutic Needs**

This question generated more specific comments than any other on the instrument. The major criticism concerned the lack of space for each of the items. Respondents believed that every item needs an “other” category and space to describe the conditions that are checked. A professional association felt that each item should have an assessment of the patient’s potential for self care, and a beneficiary group felt that there should be an assessment of the capacity of the patient or caregiver to carry out therapeutic needs.

**a. Skin:** A number of respondents [3 hospitals, government agency, accrediting agency, nursing content expert, medical professional association] indicated the need for more space to allow for reporting of multiple pressure ulcers, and a hospital and a fiscal intermediary suggested the addition ‘of a body map that would allow more accurate site location. Other suggestions under pressure ulcer were to add “size”

[medical professional association], to indicate the date of the onset of the ulcer [hospital], and to add a line for potential risk, since many elderly patients may need education or equipment for prevention prior to discharge [hospital].

Under wound care, “type of wound” should be added [medical professional association]. For both pressure ulcer and wound care, description of the drainage/culture (rather than just a check box) would be helpful [case management agency]. The need for special equipment might also be mentioned here.

Another respondent suggested adding skin conditions requiring attention, such as dry, scaly, **eczema**, ecchymosis.

**b. Nutrition:** Suggested changes included: indicate if therapeutic diet is prescribed; indicate the route for parenteral feeding (central or peripheral); enteral feeding should include jejunostomy tubes and other choices [professional association]. Two respondents [hospitals] felt that functional issues that influence consumption, such as ability to swallow or loss of taste or smell, should be included here.

**c. Hydration:** A hospital provider association and a government agency wanted the amounts of fluid encouragement and/or restriction recorded here.

**d. Respiratory:** Several respondents [equipment provider association, professional association, home health agency, hospital] recommended that this section conform to “Medicare Coverage Issues: Home Use of Oxygen” (Section 60-4), which requires the inclusion of a physician-ordered blood gas study, PO<sub>2</sub> or oxygen saturation levels, continuous or intermittent, frequency, volume, pressure, FIO<sub>2</sub>, and rate.

Others suggested a place to indicate the use of portable oxygen, nebulizers, continuous positive air pressure (CPAP) equipment, and other equipment [equipment provider association]. The instrument should also have a box for shortness of breath after a specified activity level [fiscal intermediary].

**e. Elimination:** Several respondents [nursing professional association, fiscal intermediary, hospital] wanted space to describe urinary and bowel management and/or training, especially if it requires an attendant or special equipment. Other suggestions included identifying bowel pattern and use of cathartics or enemas [hospital], diarrhea [hospital], and age of any ostomy [fiscal intermediary]. A professional association did not want to abbreviate CAPD (Chronic Ambulatory Peritoneal Dialysis), since they felt many will not know this abbreviation.

**f. Medications:** The lack of space for oral medications, the route of administration most likely to be used by patients being discharged from the hospital, drew more criticism than any other single item on the instrument [5 hospitals, 4 provider associations, 2 professional associations, case management agency, nursing content expert, home health agency, fiscal intermediary]. Many respondents felt this section could not capture the complexity of many patients’ medication regimen, especially multiple medications and frequency of use. More space is needed. A government agency suggested leaving space to transcribe the current physician’s orders.

Suggestions for additions included: information about allergies [fiscal intermediary]; blood products; “inhalation - type and frequency” to list aerosolized medications [professional association]; topical and PRN [fiscal intermediary]; and external infusion pumps. Suggested changes included: “implanted pump” to “implanted access” [hospital]; and, change the title of the item to “medication needs at discharge” [provider association].

## Other Therapeutic Needs

In addition to the additions and changes in the existing items, entirely **new categories** were suggested for the following:

- \*restorative nursing care [professional association]
- \*pain management [professional association]
- \*laboratory monitoring [professional association]
- \*psychological counseling [professional association]
- \*cardiovascular care [hospital]
- CVA care (rehabilitation potential) [hospital]
- other therapeutic needs (specify) [professional association]

## 4. Educational Needs

Several respondents [2 hospitals, provider group, beneficiary association] pointed out the importance of distinguishing the training needs of patients and their caregivers, especially for those with dementia. Educational needs are extremely variable, and the timeframe for measurement must be specified clearly if this question is to provide consistent data [2 hospitals].

A medical professional association felt the items should have a series of check boxes, indicating: 1) whether or not training had been provided in the hospital; 2) whether additional training was needed; 3) whether the patient needs reinforcement; or 4) needs supervision. There should also be an assessment of the patient’s *ability* to learn [hospital]. Identifying educational needs may not be useful if the patient cannot absorb the information given.

A hospital was concerned about the responsibility for the training after it is identified at discharge. If the hospital identifies educational needs, but does not fulfill them, there may be liability implications.

The following were suggested as additional categories of potential educational need:

- \*oxygen/ventilator systems [accreditation agency, professional association]
- \*equipment instruction, including IV pumps and ambulatory equipment [accreditation agency, professional association]
- \*bathing equipment [accreditation agency]
- \*eating/swallowing [provider association]
- \*instrumental activities of daily living

- \*health maintenance and monitoring (e.g., pulse, blood pressure, blood glucose, urine glucose)
- \*preventative health care practices (cancer screening, immunizations, stress management, exercise)
- parenteral/enteral
- \*self management (safety, basic health practices, high risk conditions) [home health agency]
- \*substance abuse [hospital]

## 5. Therapy/Service Needs

Respondents differed strongly on the inclusion of “type and frequency” in this question. Two discipline-specific professional organizations strongly objected to its inclusion, because only licensed professionals in each field and/or a physician could provide that information. Its inclusion here was thought to imply that a discharge planner could provide this material, contrary to current Medicare guidelines. A hospital felt this question would require a physician’s order. Other individuals felt that the space should be greatly expanded to allow for more narrative [professional associations].

One respondent was unclear whether the question pertained to current services, services to be continued after discharge, or a physician order for assessment by these services [government agency]. A discipline-specific professional association and hospital were unclear on what was included under “mental health,” and how it differs from “social work.” There is also no place to indicate if the patient understands his or her therapy/service needs [hospital].

Several suggestions were made to change the terminology, including: “mental health” to “psychology” [provider association]; “speech therapy” to “speech-language pathology and audiology” to be consistent with Medicare usage [2 professional associations]; and “therapy/service needs” to “therapy/service needs after discharge” [hospital].

Suggestions for items to be added to the list included:

- \*case management [medical professional association]
- \*structured activity program [hospital]
- \*infusion preparation/therapy
- \*drug regimen review [hospital group]
- \*nursing, skilled nursing [home health group, hospital]
- \*home health aide and homemaker [professional association]
- short term and long term goals for each therapy/service [professional association]

## 6. Durable Medical Equipment Needs

Once again, there was some ambiguity regarding the period of time referred to in the question, with a suggestion to add “after discharge” to the title [hospital]. A medical professional association felt the items were more oriented to nursing home

care than home care. Several respondents felt more space was needed in the “disposable supplies” section [2 hospitals, provider association].

Suggestions for items to be added to the list included:

- \*patient lifts [provider association, professional association]
- \*pressure relieving mattress [provider association]
- \*whether bed is manual or electric [provider association]
- \*cane [hospital]
- \*bathroom safety equipment (grab bars, tub transfer benches) [3 professional associations]
- \*infusion pumps [professional association]
- assistive devices (augmentative communication device, artificial larynx, hearing aid) [professional association]
- \*ventilator [professional association]
- \*suction [professional association]

## **VI. FAMILY AND COMMUNITY SUPPORT**

### *General Comments:*

The format of the section was felt to be cumbersome and confusing. A comparatively large number of respondents commented specifically on the lack of space in this section.

One hospital said that “this is the center of the discharge planning process,” and that this section should be moved to the beginning of the instrument.

Several respondents [3 hospitals] suggested asking the patient to rate his or her satisfaction with the current primary caregiver. Since these questions are of a potentially sensitive nature (e.g., the patient indicates that his family is unwilling to help), issues of confidentiality and whether the family members will have access to this section should be thought through [hospital, professional association].

### *Specific Comments:*

#### **A. Primary Support**

The most common comment on this section concerned the grid format. Respondents felt the space was completely inadequate and somewhat unclear in organization [government agency, 6 hospitals, 3 professional associations, home health association, beneficiary organization]. The distinction between “availability,” “ability,” and “willingness” was felt by several respondents to be unclear or overlapping [3 hospitals, government agency, 2 professional associations]. The manual should include more information and specific examples of each if these terms are retained [professional association]. The *type* of support given by family members should be elicited [professional association]. The level of “other caregiver” should also

be listed if this is not a family member (e.g., personal attendant, certified homecare aide) [2 hospitals].

Respondents also suggested the collection of more in-depth information regarding the primary caregiver, which would include an interview with the person, his or her legal relationship to the patient, and advanced directives such as power of attorney [provider association, academic content expert].

A provider association suggested combining this section with IV.A (Usual Living Arrangements) and VII (Patient/Family Goals and Preferences) and creating a new section entitled "Patient Preferences and Family Support." This group felt that it was not necessary to specify whether the caregiver is available, able, and willing to provide support, since availability is the key issue.

### C. Community Services

Several respondents suggested adding the frequency and duration of service to each item, as well as determining if the services are still available [beneficiary association, hospital]. One respondent felt that the phone number of the provider, in addition to the name, would be useful [professional association].

A case management agency was unclear how "community supports used before hospitalization" related to post-discharge community support *needs*. There does not seem to be a place on the instrument where the needs are clearly addressed, unless it is in Section VIII.F. (Viability of Plan for Community Services).

Suggestions for items to be added to the list included:

- \*personal care [hospital]
- \*infusion company, to be consistent with language in the Medicare Catastrophic Act of 1988 [accrediting agency, professional association]
- \*rehabilitation services [professional association]
- adult day care, medical and/or social
- telephone lifeline or telephone reassurance [professional association]
- \*legal services [professional association]
- \*respite care
- \*hospice
- \*emergency shelter/emergency services [provider group]

## VII. PATIENT/FAMILY GOALS AND PREFERENCES

### *General Comments:*

Several respondents [4 hospitals] expressed the concern that the patient's and family's desires may not be consistent with a safe and appropriate discharge plan. While the patient's wishes are always taken into consideration, it is unclear from this section the degree to which those wishes should take precedence when they disagree

with the professional's assessment. In a similar vein, a hospital felt the physician's recommendations for continuing care services should appear here.

The format of this section was once again problematic. Many respondents felt this was an important section, and merited much more space [hospitals, provider association, professional association]. If the patient's wishes are the focus of discharge planning, the position of the section (currently at the end of the instrument) should be changed.

A few respondents felt the information gathered here could be incorporated into other sections of the instrument. These included: Section VI (Family and Community Support) [professional association]; Section VIII.A. (Goals for Continuing Care) [professional association]; and into a more fully developed "Attestation of Participation" form [hospital]. A professional association felt that a timeframe for reevaluation of patient/family goals should be set to facilitate reentry into appropriate systems of care.

#### *Specific Comments:*

#### A. Patient's Goals and B. **Family/Caregiver's** Preferences

A medical professional association felt it was important to specify both short term (one month) and long term (three month) goals and preferences. Others suggested changing "continued care" in the stem of the item to "continuing care" or "ongoing care" [professional association, nursing content expert].

A provider association suggested combining these questions into a single item reflecting "patient/family preferences for continued care" and placing it in a new section on "Patient Preferences and Family Support."

#### C. Advanced Directives

Generally, respondents liked this section because it helps focus the family and patient on legal planning. Many patients may have never considered these issues. However, two hospitals felt it was not relevant to discharge planning in an acute care setting and could not be completed by the discharge planner from hospital records. Another hospital's experience was that legal issues rarely surfaced. Others felt that the question should more clearly indicate the patient's wishes in the event of incapacity [provider association, beneficiary organization]. If the patient wants assistance in obtaining any of these items, what are the hospital's responsibilities and potential liability [hospital]?

Many respondents pointed out that living wills are not valid in all states. Others believed that "durable power of attorney for health care decision making" should be added as it is more germane and not the same as "durable power of attorney," which is more encompassing [3 professional associations, provider group, nursing content expert, beneficiary organization]. A beneficiary organization was unclear of the Panel's intent for the category "requires" and who would determine this.

Other suggested additions and changes included:

- \*add “do not resuscitate” order [provider group, medical professional association]
- add “do not hospitalize” order [provider group]
- \*split “desires/requires” column into two separate columns [hospital]
- if there is a guardian, record the name [hospital]
- \*provide appropriate documentation of “medical incapacity” if applicable
- add “representative payee” to the “guardian/conservator” category [hospital]

## VIII. SUMMARY OF ASSESSMENT OF NEEDS **FOR CONTINUING CARE**

### *General Comments:*

Consistent with concerns expressed in other sections, some respondents [hospitals] felt this called for a *decision* on post-acute care, while the instrument is aimed at *assessment* of needs. The leap from gathering the information to determining the proper discharge plan is a complex one, and a mechanism must be developed for this purpose, especially if the instrument is to be used for payment determination.

The need for clarity in the terminology used in this section was also of concern to respondents. They questioned each item, not understanding some of the terms that were used, or the intent of the question. A clear explanation of the goal of this section in the proposed instruction manual would be particularly helpful.

A hospital provider association suggested a major restructuring of this section into a new section entitled “Plan for Continuing Care,” to consist of five parts: list of placement options based on Sections VIII.C. and VI.C.; assessment of home safety and access, based on Sections IV.A.2. and IV.A.3.; the viability of the plan, which would evaluate the availability and affordability of needed services, based on Section VIII.F.; a statement of the recommended plan; and space for remarks, listing the practitioner responsible for managing the patient’s continued care, and the signed attestation of the practitioner responsible for coordinating the discharge plan, based on Section VIII.H.

Two respondents, [professional associations] suggested adding a question on “sources of information” that would precede the “assessor’s signature” section. The options would include: medical record; assessor observation; patient; caregiver (identify the individual); professional (MD, RN, identify); other (identify).

There was a suggestion that the two major issues in directing patients to an appropriate post-acute care setting are new learning ability and motivation [professional association]. These should be added at some point. There was also concern as to the timing of the completion of this section, questioning whether it was to be done at the time of discharge or begun on admission [hospital].



### *Specific Comments:*

#### A. Goals for Continuing Care

Most respondents agreed that this question needs more space [3 professional associations, hospital]. A fiscal intermediary was unclear as to who was setting these goals, since information has been gathered on patient wishes as well as the discharge planner's assessment. A government agency was unclear whether care goals (e.g., rehabilitation to a certain level) or patient transfer site goals (e.g. nursing facility) were meant here. A professional association suggested adding both short term and long term goals and rehabilitation potential.

#### B. Physician or Other Provider Responsible

A number of respondents felt this question was confusing, feeling that the referring or consulting physician would always be the responsible provider, and that the phrase "or other provider" should be eliminated [2 hospitals, medical professional association, home health group]. Another suggestion was to leave space for the physician's phone number [hospital].

#### C. Options for Disposition

Two respondents [professional association] suggested calling this section "placement options," rather than using the term "disposition." It was unclear to one respondent [fiscal intermediary] if this determination was to be made as a summary score from the entire instrument, and a professional association was concerned that the question calls for a conclusion, rather than an assessment of needs.

Other suggestions included:

- \*distinguish between institutional and non-institutional care in grouping the categories [provider association]
- \*"subacute care" needs explanation [nursing content expert, 2 professional associations, provider association]
- \*"rehabilitation facility" should include both "rehabilitation agencies" and "comprehensive outpatient rehabilitation facilities" to be consistent with current Medicare terminology
- \*change "intermediate" and "skilled care" to "nursing facility" to be consistent with new Medicare terminology [professional association]
- \*"type of home care services" needs more space

Suggestions for additional categories included:

- \*chronic care facility or chronic hospital [nursing content expert]
- \*household income level if outside services are needed [beneficiary group]
- \*acute care hospital, if instrument is to be used by nursing facilities [professional association]
- \*board and care facilities [professional association]
- \*adult day health care [professional association]

- \*need for 24 hour attendant [professional association]
- \*other (specify)

#### **D. Evaluation of Informal Caregiver**

Two respondents [accrediting agency, fiscal intermediary] asked for a definition of “informal caregiver.” Another suggested adding “patient supports decision for continuing care arrangement” and “family or caregiver supports decision for continuing care arrangement” [professional association]. Another suggested moving this question to Section VI. (Family and Community Support) [provider association].

#### **E. Recommendations for Community Services**

A professional association suggested replacing “community services” with “post hospital discharge services” since it includes both community and institutional services. Two respondents [professional associations] thought this question **was** similar to Section VI, and should be combined with it, either by placing it on the same page as Section VI or repeating the list of services that appears under **VI.C.** (Community Services Utilized Prior to Admission) . A case management agency and a beneficiary group felt questions E and F (Viability of Plan for Community Services) should be combined, while another suggested listing the name and phone number of each recommended service [professional association].

#### **F. Viability of Plan for Community Services**

Once again, there was the suggestion to replace “community services” with “post hospital discharge services,” and a suggestion to change the title to “Viability of Plan for Community Services Patient Can Afford.” The meaning of “wait” was unclear to one hospital, and another thought that “viability” was redundant [professional association]. Several commented on the lack of space for the question [hospital, beneficiary group].

#### **G. Needs/Options Discussed with Patient/Family**

Several respondents suggested specifying whether the discussion had been with the patient *or* family [professional association, government agency]. Others felt this information could be better captured in Section VII (Patient/Family Goals and Preferences). One felt the patient signature should be here, rather than on the attestation form [professional association]. Suggested additions included:

- \*patient/family agrees to plan
- \*patient/family participated in completing the form
- \*patient/family is willing to follow through with the plan [hospital]
- space** for comments, such as “patient reluctant to spend money for services, family resources [beneficiary group, government agency]

## **H. Physician or Provider Responsible for Discharge Plan**

A medical professional group suggested deleting “or provider” from this question, since the physician is responsible for discharging the patient from the hospital. Other changes were to write the phone number of physician, and to change the question to “identify physician who would write orders for the patient’s continuing care.”

## **Assessor’s Signature**

Several respondents suggested listing all those who had participated in the assessment of various sections, with their signatures.

## **CONCLUSION**

This summary of the HCFA-solicited comments on the Uniform Needs Assessment Instrument provides the Panel with a great deal of information on how the draft instrument could impact on Medicare beneficiaries and the facilities that care for them. The tone of the comments was generally positive, with most respondents feeling that the Panel has done a good job in responding to the mandate given to it by Congress.

Except for a few specific items, there was not unanimity by respondents on the revisions that should be carried out. That is, the solicited comments do not provide a clear mandate from the “field” as to how the instrument should be changed. However, the comments *do* provide a rich and diverse set of suggestions that should be seriously considered by the Panel as it makes its final recommendations to the Secretary. These suggestions should increase the usefulness of the final instrument in improving the continuity of care for Medicare beneficiaries.

ADDRESSOGRAPH:

**DRAFT**

**ASSESSMENT OF NEEDS FOR  
CONTINUING CARE**

**I. SOCIODEMOGRAPHICS**

*Attach Admission Face Sheet. List the following information if not otherwise available.*

1. Name:		2. Address:		3. Phone No.:	
4. Birthdate:	5. sex: <input type="checkbox"/> U <input type="checkbox"/> F	6. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown		7. Religious Preference: <input type="checkbox"/> Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Jewish <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
8. Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		9. Education: (Highest Level Attained)		10. Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Unknown	
11. Health Care Coverage: <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private insurer (Specify _____); <input type="checkbox"/> Veteran with service related disability <input type="checkbox"/> Guarantor _____					
12. Does the patient speak English? <input type="checkbox"/> YES <input type="checkbox"/> NO		3. Primary language if not English: _____			

**II. HEALTH STATUS**

A. Physical Health		2. Subsequent Diagnosis(es):		3. Surgical Procedure(s):		4. Discharge Diagnosis	
1. Admitting Diagnosis:							
5. Known Health Problems/Risk Factors that Affect Post-Discharge Care Needs:							
<input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Renal Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Arthritis <input type="checkbox"/> Fractured Bones/Contractures <input type="checkbox"/> Amputations <input type="checkbox"/> Pressure Ulcer <input type="checkbox"/> Obesity <input type="checkbox"/> Alzheimers/Parkinsons/Other Neurodegenerative Disease <input type="checkbox"/> CVA				<input type="checkbox"/> Falls in Past Year <input type="checkbox"/> Dizziness <input type="checkbox"/> Blindness <input type="checkbox"/> Deafness <input type="checkbox"/> Food/Fluid Intake Problem <input type="checkbox"/> Substance Misuse: <input type="checkbox"/> Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Other Drugs <input type="checkbox"/> HX Non-Compliance with Therapeutic Regimen <input type="checkbox"/> Other: _____			

6. Additional information regarding patient's condition that affects post-discharge care needs:

**B. Mental Health:**

1. Level of Consciousness:

- |  |   |
|--|---|
| <input type="checkbox"/> Alert (awake, normal reaction time)                               | <input type="checkbox"/> Obtunded (appears asleep but awakens readily, slowed reaction time)          |
| <input type="checkbox"/> Drowsy (appears asleep but awakens readily, normal reaction time) | <input type="checkbox"/> Stuporous (appears asleep but awakens with difficulty, slowed reaction time) |
| <input type="checkbox"/> Lethargic (awake but with slowed reaction time)                   | <input type="checkbox"/> Comatose (unarousable)   |

2. Check those cognitive/behavioral factors that would adversely affect post-discharge care needs:

- |   |  |
|---|--|
| <input type="checkbox"/> Impaired Orientation (unaware of person, place or time)  | <input type="checkbox"/> Delusions and/or Hallucinations (perceives what does not exist: thoughts of persecution, paranoia of grandiosity) |
| <input type="checkbox"/> Impaired Memory (forgetful to the point of being dysfunctional)  | <input type="checkbox"/> Wandering (does not understand territorial constraints, leading to unsafe situations)                             |
| <input type="checkbox"/> Impaired Comprehension (difficulty in understanding spoken or written directions)                      | <input type="checkbox"/> Agitation (anxiety; restlessness)   |
| <input type="checkbox"/> Impaired Expression (difficulty in communicating needs verbally or in writing)                         | <input type="checkbox"/> Physically Assaultive (strikes self or others, causing dangerous condition)                                       |
| <input type="checkbox"/> Impaired Judgment (unsafe self-direction; inconsistency in care decisions)                             | <input type="checkbox"/> Unusual Behavior (inappropriate verbalization; reclusiveness, hoarding)   |
| <input type="checkbox"/> Depression (appears sad, helpless, hopeless; has difficulty with concentration, sleep and/or appetite) | <input type="checkbox"/> Other _____   |
|   | <input type="checkbox"/> Other _____   |

### III. FUNCTIONAL STATUS

See manual for complete definitions and instructions. Rate observed or reported performance only. Rating assumes patient is able to function safely.

- Key:** 1 Complete Independence: Patient performs safely without assistance.  
 2 Modified Independence: Patient performs safely using assistive device or requiring more time than is reasonable.  
 3 Modified Dependence: Patient performs safely at least half of the activity.  
     A Patient needs standby assistance without physical contact; verbal cueing to anticipate safety hazards: coaxing; helper sets up needed items.  
     B Patient needs minimal contact assistance.  
     C Patient needs moderate contact assistance.  
 4 Complete Dependence: Patient performs less than half of the activity.

**A. Rate level of Independence for the following (code performance as above):**

- ☐ Eating (act of bringing food to mouth, chewing and swallowing)  
☐ Bathing (bathing body from neck down, excluding back and shampooing hair)  
☐ Dressing (setting out clothing and dressing entire body, including necessary prothesis/orthosis)  
 Toilet Use (use of toilet, urinal, bedpan; includes cleansing self after elimination and adjusting clothing)  
☐ Bowel Management (intentional control of bowel movements; includes use of agents necessary for bowel control)  
☐ Bladder Management (intentional control of urinary bladder; includes use of agents necessary for bladder control)  
☐ Transfer (transferring to and from bed, chair or wheelchair; includes coming to a standing position)  
☐ Locomotion (includes walking, once in a standing position; using a wheelchair indoors)  
 Check most frequent mode of locomotion at discharge:  
☐ Walking  
☐ Wheelchair

**C. Instrumental Activities of Daily Living (complete only if considering return to a community residence):**

	Independent		Assistance Available (if required)		Unknown
	Yes	No	Yes	No	
Meal Preparation (includes cooking food and setting up meal)					
Medication Administration					
Telephone Use					
Housekeeping					
Shopping					
Handling Finances					
Transportation Use					

**B. List medical restrictions that would change above ratings:**

### IV. ENVIRONMENTAL BARRIERS TO POST-DISCHARGE CARE

**A. Usual living arrangements:**

1. ☐ Home/Apartment  
☐ Rented Room  
☐ Board and Care/Personal Care Facility/Retirement Home  
☐ Skilled Nursing or Intermediate Care Facility  
☐ Abode  
☐ With Spouse  
☐ With Others, Specify: \_\_\_\_\_  
 a Other \_\_\_\_\_

2. 

	Yes	No
Are noninstitutional living arrangements available?		
Are there barriers to building entry?		
Are there internal barriers?		
Is toilet/tub/shower accessible?		
Is the patient able to access emergency assistance?		
Other _____		

**3. Describe environmental barriers and proposed environmental modifications:**

### V. NURSING AND OTHER CARE REQUIREMENTS

**A. Check continuing care needs affecting post-discharge care requirements:**

1. ☐ Skilled Observation \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 2. ☐ Monitoring/Supervision/Evaluation \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## V. NURSING AND OTHER CARE REQUIREMENTS (CONTINUED)

### 3. Therapeutic Needs

- a. Skin: ☐ Pressure Ulcer Care: -Stage        Eite        ☐ Drainage/Culture ☐ Care:                       
☐ wound Care: -Size        Site        ☐ Drainage/Culture ☐ Care:
- b. Nutrition: ☐ Therapeutic Diet                                       
☐ Enteral Feeding: ☐ Nasogastric ☐ Gastrostomy Type and Frequency:                       
Parenteral Feeding: Type and Frequency:
- c. Hydration: ☐ Encourage Fluids ☐ Restrict Fluids                       
☐ Intravenous Hydration Route: ☐ Peripheral ☐ Central  
Type and Frequency:
- d. Respiratory: ☐ Oxygen: ☐ Continuous ☐ Intermittent Frequency:                       
Delivery Method and Liter Flow:                       
☐ Tracheostomy: Type and Frequency of Care:                       
☐ Suctioning: Frequency:                       
Ventilator: ☐ Temporary ☐ Permanent
- e. Elimination: ☐ Urinary Catheter: ☐ Indwelling ☐ Intermittent  
Type:                      Site:                      Insertion Date:                       
Irrigation and Frequency of Care:                       
☐ Ostomy: ☐ Type and Frequency of Care:                       
☐ Dialysis: ☐ Hemo ☐ Peritoneal ☐ CAPD  
Treatment Frequency

### f. Medications:

- ☐ Subcutaneous: Type and Frequency:                       
Intramuscular: Type and Frequency:
- E I Intravenous: ☐ Antibiotics ☐ Chemotherapy ☐ Blood Products  
Type and Frequency:
- Implanted Pump: Type and Frequency:
- E I Other:

### 4. Educational Needs:

- ☐ Activities of Daily Living  
☐ Self-Management of Illness  
☐ Diet Instruction  
☐ Medication Administration  
☐ Ostomy Care  
☐ Wound Care/Dressing Change  
☐ Tracheostomy Care/Suctioning  
☐ Other

### 5. Therapy/Service Needs:

- |   | Type and Frequency          |
|---|-----------------------------|
| <input type="checkbox"/> Physical Therapy.                  | <u>                    </u> |
| <input type="checkbox"/> Occupational Therapy.              | <u>                    </u> |
| <input type="checkbox"/> Speech Therapy.                    | <u>                    </u> |
| <input type="checkbox"/> Respiratory Therapy.               | <u>                    </u> |
| <input type="checkbox"/> Social Work...                     | <u>                    </u> |
| <input type="checkbox"/> Mental Health.                     | <u>                    </u> |
| <input type="checkbox"/> Other: <u>                    </u> | <u>                    </u> |

### 6. Durable Medical Equipment Needs:

- ☐ Bed ☐ Siderails ☐ Trapeze ☐ Commode  
☐ Walker ☐ Wheelchair ☐ Oxygen  
☐ Other:
- ☐ Disposable Supplies:

## VI. FAMILY AND COMMUNITY SUPPORT

A. Primary Support (for physical, mental, economic, and/or social needs)						C. Community Services Utilized Prior to Admission:	
Name: Address: Phone:	Relationship	Availability Ability Willingness Limitations (To Provide Support) or Constraints				Name of Provider	
		Availability	Ability	Willingness	Limitations		
Other Caregiver:						Home Health Services	<u>                    </u>
						Meals to Homebound	<u>                    </u>
						Adult Day Care	<u>                    </u>
						Transportation	<u>                    </u>
						Equipment/Supplies	<u>                    </u>
						Homemaker Services	<u>                    </u>
						Case Management	<u>                    </u>
						Mental Health Services	<u>                    </u>
						Other	<u>                    </u>
<input type="checkbox"/> No Known Support							

### B. Additional Assistance Needed (For Home Care):

DRAFT

## VII. PATIENT/FAMILY GOALS AND PREFERENCES

A. Patient's goals and preferences for continued care: C.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	Already Has	Desires/Requires
Durable Powerbf Attorney.		
Living Will.		
Guardian/Conservator.		

B. Family/caregiver's preferences for continued care:

\_\_\_\_\_

\_\_\_\_\_

## VIII. SUMMARY OF ASSESSMENT OF NEEDS FOR CONTINUING CARE

A. Goals for Continuing Care:

B. Physician or Other Provider Responsible for Continuing Health Care Management:

C. Based upon information obtained from the needs assessment, there are the following options for disposition:

- ☐ Home (no additional services necessary)
- ☐ Relative's home
- ☐ Home with home care services
- Type \_\_\_\_\_
- ☐ Hospice
- ☐ Adult day care

- ☐ Board and care/personal care facility/retirement home
- ☐ Intermediate care facility
- ☐ Skilled nursing facility
- Rehabilitation facility
- E I Subacute care

D. Evaluation of informal Caregiver as a Resource.

- ☐ Able to provide support as needed
- ☐ Able to provide support with assistance
- Specify \_\_\_\_\_

E. Recommendations for Community Services:

F. Viability of Plan for Community Services:

Description of Service	Service Exists	Patient is Eligible	Patient Can Afford	Availability Now	Wait

G.

Needs/options have been discussed with patient/family. . . . .

Patient/family is aware of above needs/options. . . . .

Yea	No

H. Physician or Provider Responsible for Discharge Plan:

Remarks:

ASSESSOR'S SIGNATURE:

DATE:

**DRAFT**

**U.S. Department of  
Health and Human Services**  
Health Care Financing Administration  
6325 Security Boulevard  
Baltimore, Maryland 21207

---

Official Business  
Penalty for Private Use, \$300.



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**HEALTH CARE FINANCING ADMINISTRATION**  
HCFA Pub. No. 10957      December 1992